PSYCHODYNAMIC INFLUENCES ON HUMAN SUBJECT RECRUITING PRACTICES

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Abstract: This article considers the psychological principles of transference and countertransference in the clinical trial setting, with particular emphasis on human subject recruiting practices. Transference is a Freudian concept, but one that physicians and researchers should understand. Subjects’ deep psychological issues may affect both the recruiting and consent processes because some subjects will “transfer” their emotions onto the researcher and some researchers will “countertransfer” their emotions onto their subjects.

The Silent World of Researcher and Subject?
Jay Katz’s The Silent World of Doctor and Patient (Johns Hopkins University Press, 2002) analyzed two issues—transference and countertransference—which are part of every doctor-patient relationship. His book dealt largely with topics that doctors and patients did not discuss openly, either because doctors believed that they knew more than the patients and were not going to ask patients what they thought, or because patients believed that they did not know enough to ask intelligent questions or challenge their doctors. As a result, relevant treatment options were never discussed; Doctors gave orders, and patients obediently, and without question, carried them out. Perhaps these communications problems have improved since the book’s original publication in 1984, and perhaps not, since patient “compliance” is still a problem.

It’s not surprising that the medical profession has been described as being paternalistic—male doctors behaving like fathers dealing with their compliant children. As Katz notes, in a paternalistic setting like a traditional doctor’s office, paternalistic and authoritarian physicians simply did not discuss certain topics with their childlike patients who had limited knowledge of medicine. Perhaps it’s naïve to expect patients treated in that setting to suddenly become more involved subjects in the consent process, when their history of health care is one of passive compliance and not one of active participation.

Unfortunately, the clinical trials literature contains little insight into psychological characteristics that subjects bring with them into the recruiting and informed consent processes. Yet, unacknowledged psychodynamic (Freudian) concepts of transference and countertransference may affect how researchers recruit subjects, influence patients’ decisions to participate or not participate in a clinical trial, and impact the consent process.

Two examples illustrate how such psychodynamics can affect doctor-researcher/patient-subject relationships. A university research administrator told me that “I love my doctor; I would do anything for him.” That’s a psychologically profound statement because her strong emotional connection to her doctor allowed her to trust him enough to do anything he recommended. Her attitude shows how psychological factors of trust and even “love” shape the content and meaning of both doctor-patient and researcher-subject relationships.

A nurse in bioethics training on a transplant unit talked about motivations, fears, and hopes with
patients on a transplant waiting list. One patient admitted that she agreed to have a transplant because she didn’t want to disappoint her doctor. Her psychological need for her doctor’s approval - or to avoid his disapproval - led her to make a serious medical decision without carefully considering what was medically best. Her emotional and psychological needs took priority over her medical needs.

Would the two cases above be good candidates for a clinical trial? Perhaps not. Box 1 “Emotions, Relationships and Favoritism in Subject Recruiting” summarizes relevant subject recruiting issues from Federal Regulations (45 CFR 46), the Declaration of Helsinki, and the Belmont Report. While patients with strong emotional connections to their physician-researcher shouldn’t necessarily be excluded from clinical trials, those emotional connections may require different recruiting strategies from those used with patients who don’t have such strong emotional connections.

**Positive and Negative Transference**

Because we all carry with us our early childhood emotions and memories of being sick and being cared for by parents and doctors, a doctor’s visit means bringing along one’s lifetime of illness and treatment experiences. Katz notes that patients will transfer these historical emotions from their earliest caregivers (their parents) onto their doctors. Viewed from this perspective, “I love my doctor” is an example of positive transference in which patients transfer love from their parent(s), who cared for them during childhood illnesses, to the doctor, who is caring for them in adulthood. Such positive emotions are powerful, and sometimes dangerous if patients and doctors don’t recognize what’s psychologically occurring in the doctor-patient relationship.

Such transferred emotions can complicate clinical research as well, especially when patients’ doctors are also their researchers. For example, if a patient’s doctor is also conducting a clinical trial, that patient may unconsciously place more importance on “trust” and “love” and less on the informed consent process. These positive feelings and beliefs that patients bring with them affect how they relate to their doctor, and how they respond to their doctor’s offer to be in a clinical trial.

Such unrecognized emotions can create powerful—and sometimes unrealistic—patient expectations. Seriously ill patients who see their doctor-researcher as their best (only?) hope may be even more likely to transfer their emotions onto their doctor. If they’ve run out of treatment options, seriously ill patients may see their doctor-researcher as a potential healer with almost magical powers, especially if that doctor-researcher offers a “new” drug that might be better than existing drugs, perhaps contributing to “therapeutic misconceptions” that are common among clinical trial subjects. That kind of faith, and hope, isn’t always a bad thing, as long as it doesn’t sabotage the informed consent process.

Serious illnesses are so stressful, that patients may be unable to think clearly; perhaps fear overwhelms their decision-making abilities.

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**BOX 1: Emotions, Relationships and Favoritism in Subject Recruitment**

**Federal regulations (45 CFR 46):**

“An investigator shall seek such consent only under circumstances that provide the prospective subject or the representative sufficient opportunity to consider whether or not to participate and that minimize the possibility of coercion or undue influence (italics added).”

**Declaration of Helsinki:**

“When obtaining informed consent for the research project the physician should be particularly cautious if the subject is in a dependent relationship (italics added) with the physician or may consent under duress. In that case the informed consent should be obtained by a well-informed physician who is not engaged in the investigation and who is completely independent of this relationship.”

**Belmont Report:**

“Individual justice in the selection of subjects would require that researchers exhibit fairness: thus, they should not offer potentially beneficial research only to some patients who are in their favor or select only “undesirable” persons (italics added) for risky research.”

Positive transference depends upon how patients “feel” about their doctor. Some transference may be generational; senior citizens may be more likely than younger patients to view their doctors as omnipotent healers, as almost god-like individuals. Because some doctors have been willing to take on the role of omnipotent healer, doctor-patient/researcher-subject conversations may take second place to doctor-patient/researcher-subject emotions.
Because people under high stress often regress to early childhood behaviors, Freud would explain that adults facing health stresses with which they cannot cope sometimes return to more childlike ways of dealing with that stress, hoping that what worked as a child will work as an adult. In this way, childhood experiences of illness and treatment can affect people all their life, unconsciously shaping how patients relate to doctors, researchers, and the entire health care system.

Katz suggests that when people get sick, their past and present come together in ways that doctors and patients don’t always understand. By the time a researcher talks with patients about participating in a clinical trial, those patients have had a lifetime of emotional and health care experiences that are probably unknown to the researcher. Plus, when doctors give patients a diagnosis for a serious or fatal illness and then tells them about a clinical trial, patients are likely to be at such an emotional level that they cannot make a cognitively informed decision about whether or not to participate in that clinical trial. Recognizing this, some doctors give patients and their families some time to deal with the diagnosis before approaching them about a clinical trial, although there are cases in pediatric oncology where children have to be enrolled in a trial almost immediately after a diagnosis is made.

**Table 1 - Psychodymanics in Clinical Trials**

<table>
<thead>
<tr>
<th>Psychodynamics</th>
<th>Type of Transference</th>
<th>Emotions</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transference</td>
<td>From patient to MD</td>
<td>Patient regresses to childhood: confuses past with present, parents and doctors</td>
<td>Is informed consent possible?</td>
</tr>
<tr>
<td>1) Positive</td>
<td>1) Love, trust faith</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Negative</td>
<td>2) Lack of trust</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Countertransference</td>
<td>From MD to Patient</td>
<td>1) Ego and power; exploitation</td>
<td>1) Magical thinking; hype experimental drug benefits</td>
</tr>
<tr>
<td>1) Positive</td>
<td>1) Likes / loves patient</td>
<td></td>
<td>2) Deny clinical trial participation</td>
</tr>
<tr>
<td>2) Negative</td>
<td>2) Dislikes patient</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Based on Katz’s book, concepts of transference and countertransference (Table 1) are particularly relevant, not only to doctors and patients, but also to researchers and subjects in clinical trials, especially when one’s personal physician is also one’s researcher. Sometimes, doctors fall in love with their patients, a Freudian example of countertransference in which doctors respond to their patient’s emotions by transferring their emotions back on to the patient. Such countertransference creates serious boundary issues that turn a therapeutic relationship into an exploited relationship between a powerful doctor and a vulnerable patient. While it’s not unusual to hear patients say, “I love my doctor,” most doctors would not
say “I love you” to a patient or tell their colleagues that “I love my patients.” What would that kind of countertransference do to the informed consent process?

**Summary**

Doctors’ power, including the power which patients give them and may want them to have, can encourage some patients to become so dependent upon them that they won’t challenge or question them either about medical treatment or research. In extreme cases, some patients may have such complete trust in their doctors that when their doctor suggests a clinical trial, these patients immediately want to sign up without further informed consent discussions. This decision to participate may be made well before the offer to participate is even suggested. Because these patients believe (or want to believe) that their doctors have the (magical?) power to heal them, their trust and emotions are outweighing the risks of participating in a clinical trial and prevent them from taking a more analytical approach to deciding whether to participate.

Being on the receiving end of so much trust from patients means that doctors-researchers may engage in their own magical thinking to justify that trust, perhaps by unconsciously hyping a clinical trial’s benefits, or by calling a drug that has not even gone through clinical trials a “breakthrough drug,” or by describing the investigational drug/procedure as a “new treatment”. Such magical thinking may lead doctors to promote magical clinical trial benefits that meet the magical treatment hopes of patients:

Sometimes people believe what they need to believe.