DRUG & ALCOHOL FINDINGS *Review*

analysis

This entry is our analysis of a review or synthesis of research findings added to the Effectiveness Bank. The original review was not published by Findings; click Title to order a copy. Free reprints may be available from the authors – click prepared e-mail. Links to other documents. Hover over for notes. Click to highlight passage referred to. Unfold extra text The Summary conveys the findings and views expressed in the review. Below is a commentary from Drug and Alcohol Findings.

▶ Evidence-based psychotherapy relationships: Managing countertransference.

Hayes J.A., Gelso C.J., Hummel A.M.

Psychotherapy: 2011, 48(1), p. 88–97.

This meta-analytic review commissioned by the American Psychological Association finds that therapists with the self-awareness and other abilities to recognise, understand and use their reactions to clients, even when these are driven by the therapist's own internal conflicts, do better therapy and have more satisfied clients.

SUMMARY Updated in 2018. See Effectiveness Bank analysis.

[Though not specific to patients with drug and alcohol problems, studies in the analyses described included such patients, and the principles are likely to be applicable to these disorders among others, not least because substance use problems generally form part of a complex of broader psychosocial problems.]

This review is one of several in a special issue of the journal *Psychotherapy* devoted to evidence-based, effective therapist-client relationships. It reports on a three research synthesis related to 'countertransference' – the therapist's 'human', emotional reactions to the patient as opposed to their deliberate therapeutic manoeuvres.

In the classical Freudian tradition, 'transference' involves the patient unconsciously placing the therapist in the role of a significant person in their past and reacting to them accordingly, re-enacting past relationships, particularly from childhood. Therapists in this tradition use transference to reveal the patient's unresolved conflicts with childhood figures. 'Countertransference' refers to similar reactions by the therapist to the patient placing them in these roles, deriving from unresolved issues from the therapist's childhood, reactions to be eliminated if possible through the therapist's own psychoanalysis. Later conceptualisations saw the therapist's reactions as (if the therapist can become aware of them and 'stand back' and understand them) providing valuable material to aid the therapist's understanding of themself and of their patients.

The present authors favoured an amalgam of these and other views which defines countertransference as inevitable reactions deriving from the therapist's unresolved conflicts, yet still see these as potentially valuable if therapists can understand them and use them to help understand the patient, rather than just reacting. These reactions occur not just to the patient's transference, but their personality, what they say and do, and even their appearance.

Such a definition accords with how in practice countertransference has been assessed in studies. Most of the measures used implicate the therapist's unresolved conflicts as the source, often triggered by the patient's characteristic. The reactions may be identified by: assessing the therapist's emotional state; discrepancies between how they see a therapy session or a client and more objective assessments, for example, based on session transcripts; or the therapist's actual behaviour revealing under- or over-involvement with the patient and/or what the patient is presenting. Several scales or rating systems have been developed to quantify the degree of

countertransference. When studies of therapists' management of these reactions have employed such a scale, nearly all have used the Countertransference Factors Inventory. This assesses five therapist attributes thought important to successfully managing their reactions to the patient: self-insight; self-integration; anxiety management; empathy (an attribute dealt with in another paper in this special issue of *Psychotherapy*); and conceptualising ability.

The current review tackles three related issues:
1 Do countertransference reactions affect the outcomes of therapy? Addressed by assessing whether the extent of countertransference is related to patient progress;
2 Do the therapist's skills, ability or attempts to manage countertransference actually curb these reactions? Again assessed by the relation between the two; and
3 Do these more able or more actively managing therapists have better client outcomes?
If each element in this chain is supported, a plausible explanation is that countertransference reactions do impede therapy, but these reactions can be curbed by therapists who are self-aware or have other attributes related to reaction-management, and that exercising this control improves client outcomes.

To answer these questions, the analysts searched for and found 22 studies which assessed at least two of the three relevant variables: countertransference, its management, and therapy outcomes. These were used to answer the review's questions in three separate meta-analyses synthesising results from relevant studies to estimate the overall strength of the links between these variables. Strength was expressed as effect sizes using the 'r' metric, which can be squared to calculate how much of the difference in outcomes can be attributed to differences in the therapy dimension being investigated. The assumption was made that there is no single, true strength of each of three links investigated by the analyses, which appears to vary only because of methodological differences, but that strength really might vary across the studies. Some of the studies did not supply quantitative data for the analyses but did offer insights in to the processes which might underlie the quantitative results.

1 Do countertransference reactions affect psychotherapy outcomes?

Across the ten relevant studies, the strength of the link between the therapist's countertransference reactions and how the patient felt or progressed, or the quality of the therapeutic encounter, equated to an effect size of -0.16. The negative sign indicates that this small but statistically significant link means that the greater the countertransference reactions provoked in the therapists, the less well therapy progressed or the more negative the patients' reactions. However, only one study evaluated whether countertransference actually affected the ultimate success of therapy. All the others assessed patient reactions presumed indicative of success or failure, such as patient satisfaction, working alliance or the quality of the therapy session.

[Editor's note: The exception examined 20 cases of brief therapy conducted by trainees. Their clients were students seeking help at a university psychology clinic, mostly in relation to stress. Supervisors observed each session and rated the degree of countertransference. Overall there was no relationship with outcomes. But for the eight less successful cases, countertransference was strongly related to even poorer outcomes. It was argued that in more successful cases, a strong alliance mitigated the negative effects of countertransference. In this study 'outcomes' were not measures of psychological health or symptom reduction, but how much clients thought they had gained from, and their satisfaction with, the counselling. Such perceptions may be related to how well the therapist related to them, but not necessarily to how well the patient's problems were resolved. Also, unless planned in advance, sub-sampling the full set of patients in this way risks generating false positive results.]

Studies documenting the experiences of therapists suggest that countertransference can both hinder and facilitate therapy, perhaps depending on the degree to which the therapist has yet to resolve the conflict which generated the reactions. One study based on the assessments of therapists themselves also found that countertransference reactions were typical rather than confined to particularly poor or neurotic therapists.

2 Do the therapist's skills, ability or attempts to manage countertransference actually curb these reactions?

A fundamental assumption is that if the therapist's countertransference is to be turned in to a positive for the client, the therapist must do something to, with, or about their

reactions rather than simply reacting – what may be termed 'countertransference management'. Eleven studies were found which assessed the relationship between the extent or intensity of countertransference reactions, and processes clearly indicative of therapists' control of and efforts to manage their reactions. Among these efforts were deliberate self-awareness and awareness of their physical reactions, 'mindful' attention to their current thoughts and feelings, and in some studies their scores on the Countertransference Factors Inventory.

Overall there was little indication that these efforts or presumed abilities to manage countertransference actually did so. Across the studies the relationship equated to a statistically non-significant effect size of -0.14, the negative sign and the quantity suggesting at best a possible small reduction in countertransference consequent on these efforts or abilities.

However, the strength of this association varied considerably across the studies. In some the therapist's efforts and abilities do seem to have had the desired effect, showing that this *can* happen, even if not always. Among these more positive studies are those indicating that (as expected) empathic therapists are better able to manage their reactions in difficult, countertransference-provoking therapy situations. Others suggest that theoretical appreciation of countertransference is no protection against actually experiencing these reactions unless it is allied with self-awareness.

3 Do therapists with the presumed skills or ability to manage countertransference or who take steps to do so have better client outcomes?

Across the seven studies which addressed this question, the answer was emphatically, 'Yes'. Even when an unusually positive study was eliminated from the analysis, the relationship between countertransference management and various measures presumed related to therapeutic success was strong and statistically significant, equating to an effect size of 0.45, a relationship which would account for 20% of the variance in outcomes. It seems that therapists with characteristics thought to help them manage their reactions to patients are better able to help those patients, but this implication must be tempered by the fact that only one study evaluated whether countertransference management actually affected the ultimate success of therapy. All the others assessed patient reactions presumed indicative of success or failure, such as patient satisfaction and working alliance, or quality indicators such as the excellence of the therapy session or of the therapist.

[Editor's note: The exception concerned students counselled by graduate counselling psychology students at a university counselling centre, generally for not very severe problems. The graduates' counselling course supervisors rated their countertransference management abilities on the Countertransference Factors Inventory. The same supervisors and also the therapists rated outcomes for clients at the end of counselling in terms of the client's feelings, behaviour, self-understanding, and overall change, using a scale found in other studies to be related to alternative ways of assessing outcomes. These outcomes were strongly and significantly related to the therapist's countertransference management abilities, assumed to reflect the impact of those abilities on the success of therapy. These findings are (as the authors acknowledged) weakened somewhat by the limited outcome measure and the fact that this was completed not by the client or by an independent researcher, but by the therapists and supervisors and by mail. This raises the possibility of a 'halo effect' on the part of the supervisors, who might tend to see 'good' therapists as having 'good' outcomes, and of the therapists who were positive about their own therapy-related abilities also being positive about their clients' progress.]

Practice recommendations

The meta-analytic evidence points to the conclusion that the acting out of countertransference is harmful and that countertransference management probably promotes positive outcomes. Several therapeutic practices follow directly from these research-driven conclusions.

The effective psychotherapist can work at preventing such acting out and must manage internal countertransference reactions in a way that benefits the work.

Several therapist behaviours appear to be a useful part of this process. Using self-insight and self-integration as examples, the therapist's struggles to gain self understanding and work on his or her own psychological health, including boundary issues with patients, are fundamental to managing and effectively using one's internal reactions. These two factors allow the therapist to pay attention to client behaviours that are affecting them and to understand why this is the case.

One aspect of countertransference management, self-integration, underscores the importance of the therapist resolving his or her major conflicts, which in turn points to the potential value of personal therapy and clinical supervision.

The therapist can deal with countertransference even if they have already reacted to these feelings in the session. Some research points to the value of therapists admitting that a mistake was made and that it their own conflicts were the source.

If countertransference is to be managed and used for therapeutic gain, having and using a theory are not enough. The evidence suggests that theory in conjunction with personal awareness is a key to the therapeutic use of countertransference.

FINDINGS COMMENTARY This article was in a special issue of the journal *Psychotherapy* devoted to effective therapist-client relationships. For other Findings entries from this issue see:

- Evidence-based psychotherapy relationships: Psychotherapy relationships that work II
- Evidence-based psychotherapy relationships: Alliance in individual psychotherapy
- Evidence-based psychotherapy relationships: The alliance in child and adolescent psychotherapy
- Evidence-based psychotherapy relationships: Alliance in couple and family therapy
- Evidence-based psychotherapy relationships: Cohesion in group therapy
- Evidence-based psychotherapy relationships: Empathy
- Evidence-based psychotherapy relationships: Goal consensus and collaboration
- Evidence-based psychotherapy relationships: Positive regard
- Evidence-based psychotherapy relationships: Congruence/genuineness
- Evidence-based psychotherapy relationships: Collecting client feedback
- Evidence-based psychotherapy relationships: Repairing alliance ruptures
- Evidence-based psychotherapy relationships: Research conclusions and clinical practices

The special issue which contained the article featured above was the second from the task force. The first was a special issue of the *Journal of Clinical Psychology*. While the second aimed to identify elements of effective therapist-client relationships ('What works in general'), the first aimed to identify effective ways of adapting or tailoring psychotherapy to the individual patient ('What works in particular'). For Findings entries from this first special issue see this bulletin. Both bodies of work have also been summarised in this freely available document from the US government's registry of evidence-based mental health and substance abuse interventions.

Last revised 01 June 2011. First uploaded

- Comment/query
- Give us your feedback on the site (one-minute survey)
- Open Effectiveness Bank home page
- Add your name to the mailing list to be alerted to new studies and other site updates

Top 10 most closely related documents on this site. For more try a subject or free text search

REVIEW 2018 Countertransference management and effective psychotherapy: meta-analytic findings

REVIEW 2011 Evidence-based therapy relationships: research conclusions and clinical practices

REVIEW 2018 The alliance in adult psychotherapy: a meta-analytic synthesis

ABSTRACT 2011 Evidence-based psychotherapy relationships: Repairing alliance ruptures

REVIEW 2011 Evidence-based psychotherapy relationships: Alliance in couple and family therapy

REVIEW 2011 Evidence-based psychotherapy relationships: Alliance in individual psychotherapy

REVIEW 2011 Evidence-based psychotherapy relationships: Positive regard

REVIEW 2011 Evidence-based psychotherapy relationships: Goal consensus and collaboration

REVIEW 2011 Evidence-based psychotherapy relationships: Cohesion in group therapy

REVIEW 2011 Evidence-based psychotherapy relationships: The alliance in child and adolescent psychotherapy