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.

Countertransference management and effective psychotherapy: meta-analytic findings.

Hayes J.A., Goldberg S., Gelso C.J. et al.

Psychotherapy: 2018, 55(4), p. 496–507.

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[Consultation draft subject to amendment and correction.] Therapist "know thyself" is the Socratic injunction strongly suggested by findings amalgamated for the American Psychological Association. Across all relevant studies, counsellors and therapists with the self-awareness and abilities to recognise, understand and use their reactions to clients – even when these are driven by the practitioner's own internal conflicts – conduct better therapy and have more satisfied clients.

SUMMARY [Though not specific to clients with drug and alcohol problems, the principles derived from this review of psychotherapy studies are likely to be applicable, partly because severe substance use problems generally form part of a complex of broader psychosocial problems. This review updates an earlier version by the same authors also in the Effectiveness Bank. Where appropriate parts of that analysis are used here.]

The featured review is one of several in a special issue of the journal *Psychotherapy* devoted to features of the therapist-client relationship related to effectiveness, based on the work of a task force established by the American Psychological Association. This particular review analysed findings relating psychotherapy process and outcomes to the degree to which counsellors' and therapists' reactions to their clients are based on their own unresolved personal conflicts (so-called 'countertransference'), and the effects of the practitioners's ability to recognise and manage this potential obstruction to effective therapy. For more on the concept of countertransference unfold the supplementary text.

Close supplementary text

In 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. 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, deriving from the

Key points
From summary and commentary

Commissioned by a task force of the American Psychological Association, this review amalgamated findings relating evaluations of psychotherapy process and outcomes to the degree to which therapists' own internal conflicts affect their reactions to patients ('countertransference') and how well they manage those reactions.

Findings were consistent with the proposition that when a patient 'presses your buttons', it helps to know that has happened, to understand what in the patient prompted that reaction, and then how that relates to their problems and possible ways forward.

However, studies have rarely assessed final therapy outcomes, and research has not been done which could establish whether links found between therapy process/outcomes and countertransference and its management were causal, or by-products of other influences.

therapist's unresolved childhood issues – 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 and 'stand back' and understand them) providing valuable material to extend understanding of themself and of the patient.

The reviewers favoured an amalgam of these and other views, defining countertransference as the therapist's inevitable internal and external reactions in which their unresolved conflicts, usually but not always unconscious, are implicated. Countertransference is best understood as an interaction between the therapist's unresolved conflicts and aspects of the client that touch upon or stir up the therapist's conflicts. These reactions occur not just to the patient's transference, but to their personality, what they say and do, and even to their appearance. Though their understanding derived from the classical view, the reviewers saw countertransference reactions as potentially valuable if therapists can understand them and use them to help understand the patient, rather than just reacting.

Their definition accords with how in practice countertransference has been assessed in studies. Most measures assume the therapist's unresolved conflicts are the source of countertransference, often triggered by the patient ▸ panel below right. Depending on theoretical orientation, these reactions have been operationalised in behavioural, cognitive, somatic, and affective terms; from its psychoanalytic roots, countertransference is now conceptualised as transcending theoretical divisions.

Close supplementary text

In terms of behaviour, the most common signs used to recognise countertransference have been therapists' avoidance of and withdrawal from personally threatening issues raised by or prompted by the client. Avoidant reactions include those that inhibit, discourage, or divert the content of a session, such as ignoring or mislabelling emotions, changing topics, or allowing prolonged silences. Seemingly positive reactions may also indicate countertransference, including over-involvement with the client, or therapists meeting their own needs by being excessively nurturing. In terms of perceptions and thinking, countertransference has been operationalised as distorted perceptions of clients and inaccurate recall of what they discussed in sessions. Physical signs include therapists' sleepiness, muscular tension and headaches, and in the emotional domain, in-session anxiety and other positive and negative emotions.

The featured review tackled three related issues:
1 Are the therapist's countertransference reactions related to poorer patient progress?
2 When the therapist exhibits skills, ability or attempts to manage countertransference, are these reactions actually fewer?
3 When therapists are more able to or more actively manage countertransference, do they have better client outcomes?

If each element in this chain is supported, a plausible explanation is that countertransference reactions do impede therapy, but can be curbed by therapists who are self-aware or have other attributes which help manage these reactions, and that exercising this control improves client outcomes.

To answer these questions, the analysts searched for and found 36 studies of psychotherapy which assessed one or more of the three possible relationships. All were of individual rather than group, couple or family therapy. Their results were amalgamated in three separate meta-analyses addressing each of the questions by calculating the overall strength of the links between the variables, and also probing for influences which might make those links stronger or weaker. Link strength was calculated as a correlation coefficient, an expression of the degree to which the variables assessed by the analysis co-varied. The chosen metric ranged from -1 (perfect negative

Measuring the therapist's ability to manage countertransference

Studies of therapists' management of countertransference have primarily measured this using the Countertransference Factors Inventory. This questionnaire assesses five therapist attributes thought important to successfully managing their reactions to the patient:
• *Self-insight*. The extent to which therapists are aware of, and understand, their own feelings, attitudes, personalities, motives, and histories.
• *Self-integration*. Whether the therapist has an intact, basically

co-variation, meaning that as one side of the link gets larger the other diminishes) to +1 (perfect positive co-variation, meaning that as one side of the link gets larger so does the other). Effectively these correlations indicate how influential countertransference and its management might have been if not just related to patient progress, but if they actually influenced that progress.

Main findings

1. Are countertransference reactions related to psychotherapy outcomes?

Across the 14 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 a correlation 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 patients' reactions. Despite additional studies, the magnitude of this relationship is the same as found in the earlier version of this review, suggesting that it is fairly reliable and that the effects of countertransference reactions on psychotherapy outcomes, though small, can be detected. The link did not significantly vary whether session evaluations were the outcome versus end-of-treatment or post-treatment assessments.

However, there were signs that some studies had been missed from the analysis. Estimating the possible impact of these studies reduced the correlation to a non-significant -0.07.

healthy character structure.
• *Anxiety management*. The therapist's ability to control and understand anxiety so that it does not adversely affect their responses to patients.
• *Empathy*. Ability to identify with another person and put one's self in their shoes. Despite the difficulties they may be experiencing, this ability permits the therapist to focus on the patient's needs.
• *Conceptualising ability*. The therapist's ability to draw on theory and understand the patient's role in the therapeutic relationship.

Validated in 2017, the Countertransference Management Scale was developed to directly assess the management of countertransference during therapy sessions. Its 22 items boil down to two dimensions which incorporate the five attributes of the Countertransference Factors Inventory: understanding self and client (incorporating self-insight, empathy, and conceptualising ability); and self-integration and regulation (incorporating self-integration and anxiety management).

2. Do the therapist's ability or attempts to manage countertransference appear successful?

A fundamental assumption is that if the therapist's countertransference is to be turned into a positive for the client, the therapist must do something to, with, or about their reactions, rather than simply reacting – 'countertransference management'. Thirteen studies 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 thoughts and feelings, and in some studies scores on the Countertransference Factors Inventory ▸ panel above.

Across the 13 studies the relationship equated to a statistically significant correlation of -0.27, consistent with ability/attempts to manage countertransference actually working to a degree in the form of fewer countertransference reactions. However, the strength of this association varied considerably across the studies.

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 nine studies which addressed this question, the answer was positive,

equating to a statistically significant, medium-to-large correlation of 0.39, consistent with the assumption that therapists with characteristics thought to help them manage their reactions to patients are better able to help those patients. Accounting for possibly missing studies increased the estimate to large-size 0.51. The strength of this association varied considerably across the studies, though not depending on whether session evaluations were the outcome versus end-of-treatment or post-treatment assessments.

The authors' conclusions

Amalgamated evidence points suggests that the therapist's acting out of countertransference reactions is typically harmful to the patient, though not necessarily irreparably so, and that the therapist's sound management of these reactions typically enhances patient outcomes. Because of the relatively small number of studies amalgamated in each of the three meta-analyses, the magnitudes of these effects are likely to change as research accumulates, but it is unlikely that the directions of the relations will be reversed; countertransference reactions may calculated to be more or less harmful, managing these more or less helpful, but research is likely to continue to indicate they are respectively harmful and helpful.

Perhaps the most serious limitation of the research is that few studies have linked countertransference and its management to ultimate treatment outcomes. It is reasonable to infer that outcomes will worsen if countertransference leads to avoidance of a patient's feelings, inaccurate recall of the content of sessions, and becoming over-involved in the patient's problems. Similarly, it is reasonable to infer that if countertransference behaviour is negatively related to sound working alliances and to supervisors' evaluations of treatment effectiveness, then failing to manage this behaviour will worsen psychotherapy outcomes. However, there is little direct support for these inferences. Only one study has evaluated whether countertransference actually affects the ultimate success of therapy in terms of improvements in the clients. As a result, the link between countertransference behaviour and treatment outcome is tenuous.

Another limitation is that all studies to date have focused on individual therapy. The empirical literature is silent on countertransference and its management in group, couple, and family therapy.

Practice recommendations

From these rather general conclusions, a number of specific clinical practices can be recommended:

- Effective psychotherapists work at preventing the acting out of countertransference reactions.
- The five therapist attributes thought important to managing reactions to the patient appear to be useful for understanding and controlling countertransference manifestations. It seems particularly important to continually cultivate self-insight. A therapist must take seriously Socrates' advice to "know thyself" or risk unknown aspects of the self undermining work with a client.
- Practice the demanding task of honest, impartial, and persistent self-observation. Self-awareness fosters an understanding of others, and our own blind spots can interfere with our empathy for and insight into others.
- Therapists should work on their own psychological health, including healthy boundaries with patients. Self-integration and self-insight allow the therapist to pay attention to how the client is affecting them and why – first steps to arriving at ways in which countertransference may be useful. When the therapist seeks to understand internal conflicts being stirred by the patient, they also consider how this process may relate to the patient's past and present life outside the consulting room. Awareness of underlying countertransference conflicts forms a basis for the effectiveness of a therapist's responses to clients.
- The role of self-integration underscores the importance of the therapist resolving major conflicts, which in turn points to the potential value of their

own personal therapy, particularly for dealing with chronic countertransference problems.
• Clinical supervision – for experienced therapists as well as trainees – is another key factor in understanding and managing countertransference and in using it to benefit clients, especially if supervisors themselves actively conduct psychotherapy so they remain sensitive to the realities and challenges posed by countertransference.
• When countertransference has already been acted out, the therapist needs to understand that they were acting out personal conflicts. If there is a strong working alliance, some research suggests the value of admitting a mistake and that the therapist's conflicts were the primary source. Therapists need not go into detail about their problems, for doing so more often than not serves their needs more than those of the patient.
• Therapists are likely to benefit from engaging in regular and sustained meditation. Meditation promotes emotion regulation and has been found to benefit countertransference management.
• Therapists should practice self-care, including getting enough sleep, limiting their caseload, spending time with friends, eating healthily, exercising regularly, and focusing on the rewards of conducting therapy. These behaviours are associated with practitioner resilience and ultimately better psychotherapy outcomes.

FINDINGS COMMENTARY The reviewers' practice recommendations are based on the likelihood of a causal link between patients' progress and countertransference and its management – the proposition that the more a therapist either is not affected by or manages reactions to the patient which divert from knowing and helping them, the better the patient will do. Ironically, it is argued that the main way to prevent the therapist and their reactions effectively becoming the focus of therapy is to focus on those reactions, understand them for what they are, and then to make use of them to forefront what the patient needs from therapy. In plainer terms, when a patient 'presses your buttons', it helps to know that has happened, to understand what it was in the patient which led to that (which entails understanding what it was in you), and then how that relates to their problems and possible ways forward.

Given the nature of the studies which supported these recommendations, causality cannot be considered proven, but for several reasons it seems likely. First is the consistency of the associations between countertransference and its management and positive evaluations of therapy or patient welfare. In every one of the studies incorporated in the three meta-analyses, these relations were in the expected direction. Next is the (in the context of other relationships between therapy process and outcomes) the large correlation between countertransference abilities and efforts and evaluations of therapy – taking into account missing studies, 0.51, which if the relation was causal, would account for just over a quarter of the variation in these evaluations. Last is the plausibility of the proposition that if the therapist is the instrument of therapy, understanding the quirks and weaknesses of that instrument will help it be used to greater effect. Nevertheless research to confirm causality is weak, exposed most clearly in the key studies explored below.

Key studies

The reviewers warned that few studies have related countertransference and its management to the ultimate outcomes of therapy rather than the presumed process of getting to those outcomes. This means that the few studies which have assessed ultimate outcomes are key to validating countertransference management as a causal factor in leading patients not just to value the

process and their therapists, but also to achieve what they sought from therapy. What seem the two key studies were not able to offer much support for this argument.

In linking countertransference reactions to psychotherapy outcomes, the key study concerned 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 the counselling and their satisfaction with the process. Such perceptions may well be influenced by how well the therapist related to them, but do not necessarily equate to how well patients' problems were resolved. Also, unless planned in advance, sub-sampling from the full set of patients (in this case, selecting less successful cases) risks generating false positive results.

Students counselled (generally for not very severe problems) by graduate counselling students at a university counselling centre, were the subjects of what seems the key study linking client outcomes to the therapists's skills or ability to manage countertransference or the steps they take to manage these reactions. The counsellors' course supervisors rated their countertransference management abilities on the Countertransference Factors Inventory ▸ panel above. The same supervisors and also the counsellors 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 other ways of assessing outcomes. These outcomes were strongly and significantly related to the counsellors's countertransference management abilities, a finding 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 by the fact that this was completed not by the client or by an independent researcher, but over the mail by counsellors and supervisors. What cannot be ruled out is that rather than real patient progress, the findings were due to a 'halo effect' on the part of the supervisors, who might tend to see 'good' counsellors as having 'good' outcomes, and on the part of the counsellors, such that those who tended to be positive about their own abilities also tended to be positive about their clients' progress.

As they are added to the Effectiveness Bank, listed below will be analyses of the remaining reviews commissioned by the American Psychological Association task force.

Cohesion in group therapy
Treatment outcome expectations
Treatment credibility
Therapist empathy
Therapist–client alliance
Alliance in couple and family therapy
Repairing ruptured alliances between therapists and clients
Positive regard
The 'real relationship'

This draft entry is currently subject to consultation and correction by the study authors and other experts.

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

REVIEW 2018 Cohesion in group therapy: a meta-analysis

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