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Countertransference Knowledge and Substance Abuse Treatment

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Countertransference Knowledge and Substance Abuse Treatment

Submitted by Samantha Yerks, LADC
May, 2012

MSW Clinical Research Paper

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present their findings. This project is neither a Master's thesis nor a dissertation.

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Abstract

This research sought to understand the relationship between educational background, levels of education and understanding of countertransference concepts, in relation to substance abuse treatment. Previous research has identified knowledge of countertransference as a factor increasing a therapist's ability to manage countertransference and increase client success in substance abuse treatment (Seiden, Chandler & Davis, 1994). It was hypothesized that there would be a positive relationship between therapist level of education, and understanding of countertransference. It was also hypothesized that those who have an education specifically in addiction would have a poorer understanding of countertransference than those trained in social work, psychology or marriage and family therapy. This hypothesis was based on educational licensing standards in the state of Minnesota, as addiction counselors in Minnesota prior to 2008 could receive a 2 year certificate in counseling (Office of the Revisor of Statutes, 2010). This research used the Countertransference Measure developed by Hofsess and Tracey (2010). It was found that all therapists, regardless of educational background or level of education had a similar understanding of countertransference concepts. A major limitation of this research included a very small sample size (N=29) and therefore recommended that future research should obtain a larger sample size.

Introduction

Previous research has identified countertransference as a variable that can interfere with a client's success in substance abuse treatment (Forrest, 2002; Weiss, 1994; Saunders, Howard & Orlinsky 1989; Seiden, Chandler & Davis, 1994). This research intended to explore the relationship between substance abuse therapist understanding of countertransference and educational background as well as level of education. First a historical perspective of countertransference will be reviewed as well as factors that increase therapist success in managing countertransference. In addition, a review of common countertransference reactions among therapists treating substance abuse will be discussed, since previous research has identified substance abusers as one of the most difficult populations to treat (Forrest, 2002; Weiss, 1994; Imhof, Hirsch and Terenzi, 1984; Najavits et al., 1995). Moreover, addiction professional licensing required little in comparison to other human service professionals such as psychology, social work and marriage and family therapy that required at least a bachelor's degree to practice (Office of the Revisor of Statutes, 2010). Due to these licensing standards, it is hypothesized, that professionals working in the addiction treatment field will demonstrate stronger knowledge of countertransference if they have higher levels of education or are from educational backgrounds such as social work, psychology or marriage and family therapy, rather than specifically addiction counseling.

Literature Review

Brief History of Countertransference

The development of countertransference as a therapeutic factor was a long and slow process. Sigmund Freud was the first to identify countertransference and later this concept was followed by additional variables influencing the practice of psychotherapy and countertransference responses (The Concise Corsini Encyclopedia of Psychology and Behavioral Science, 2004). Although Freud was the first to discuss countertransference, therapist behavior was not brought into consideration until Sullivan's concept of "participant observer", which later challenged the neutral stance of psychotherapy (The Edinburgh International Encyclopaedia of Psychoanalysis, 2006).

Sigmund Freud's 1910 paper "The Future Prospects of Psycho-Analytic Therapy", included the first known definition of countertransference. Classical psychoanalysis identified countertransference as the therapist's unconscious unresolved conflicts and affective response to the patient (Freud, 1910). It was not until later, in the development of two person psychology or relational based perspectives that the patient's behavior was considered a factor in a countertransference. The initial definition of countertransference was based solely on the therapist's previous experiences and conflicts, meaning that the therapist was experiencing their own personal form of transference in response to working with patients (The Concise Corsini Encyclopedia of Psychology and Behavioral Science, 2004).

To Freud (1910) countertransference was the result of unresolved conflicts that interfered with the psychoanalytic process. Freud (1910) emphasized that the psychoanalyst “recognize this counter-transference and overcome it” (Freud, p. 145, 1910). Jung noted that the psychoanalyst “must have clean hands, so as not to infect the patients with their own unconscious reactions” (The Edinburgh International Encyclopaedia of Psychoanalysis, 2006, Countertransference: Jung, para 1). In essence the psychoanalyst must address his countertransference reactions to ensure the patient is not affected. Later, D. W. Winnicott recognized the impact of the therapist’s unresolved problems and suggested the analyst undergo analysis himself, to prevent damage to the patient (Winnicott, 1994).

Winnicott, in his essay “*Hate in the Counter-Transference*” also recognized the “emotional burden” that the analyst takes on as he or she treats a patient (Winnicott, 1994, p. 350). Moreover, Winnicott (1994) states, “However, much [the analyst] loves his patients he cannot avoid hating them, and fearing them, and the better he knows this the less will hate and fear be the motive determining what he does to his patients” (Winnicott, 1994, p. 350). Moreover, Winnicott likened the therapeutic relationship to the relationship between mother and child, indicating that the mother (the analyst) must set aside her own frustrations in order to comfort and understand the child, as the therapist is expected to set aside their personal or unconscious reactions and attempt to treat the patient in an objective manner (Winnicott, 1994). Yet, according to The Edinburgh International Encyclopaedia of Psychoanalysis (2006), Jung was the first psychoanalyst to identify countertransference having a positive value in therapy, this led to additional

considerations regarding therapeutic objectivity and ultimately paved the way for the therapist to be a factor in client success.

Early perceptions of analysis regarded therapeutic work under Freudian concepts of maintaining neutrality and objectivity (The Concise Corsini Encyclopedia of Psychology and Behavioral Science, 2004). Yet, as years progressed therapeutic objectivity and the one-sided treatment approach came under further evaluation. Sullivan challenged this one-person psychology perspective of the analyst as a blank screen, and opened the door for the discussion of two person psychology, through his reference of “participant observer” (The Edinburgh International Encyclopaedia of Psychoanalysis, 2006, Countertransference: Relationalism, para 1). Sullivan’s concept of “participant observer” meant that the therapist was engaged in an observational relationship with the patient, but in addition the therapist was also a factor within the therapeutic process.

According to the Edinburgh International Encyclopaedia of Psychoanalysis (2006) Sullivan’s challenge to a neutral stance, or therapist as a blank slate, in psychoanalytic work began the relational based movement, stating that the “therapist cannot, despite every effort, maintain such neutral objectivity” (Edinburgh International Encyclopaedia of Psychoanalysis, 2006, Countertransference: Relationism, para 1). After Sullivan’s redefinition of countertransference the therapist transformed from an observer in psychotherapy to an active member in the therapeutic treatment process. As a result, countertransference also transformed. Again countertransference continued to encompass all therapist affective responses, such as, previous experiences or conflicts, but countertransference now also included the patient’s behavior as a source of affective

reaction. In essence, the patient was now an additional factor in the therapist's emotional responses. Further, the countertransference response was now rich with information about the patient and the therapeutic process (The Edinburgh International Encyclopaedia of Psychoanalysis, 2006; Concise Corsini Encyclopedia of Psychology and Behavioral Science, 2004). These concepts paved the groundwork for the two person psychology and relational based movement as well as a more comprehensive definition of countertransference.

Following the definition provided by Teyber & McClure (2011), this research will include two aspects of countertransference. One will include the classical definition of countertransference: the therapist's unresolved conflicts or experiences, termed *therapist-induced countertransference*. The other, *client-induced countertransference* is defined as the reaction of the therapist in response to a client's behavior. This definition addresses both the therapist's history and the client's behavior as possible sources of countertransference. This two part definition parallels classical Freudian definitions of countertransference and Sullivan's more contemporary view of "participant observer" (Edinburgh International Encyclopaedia of Psychoanalysis, 2006; Freud, 1910). Additionally, it identifies the feelings that some therapists face when working with clients that have similar issues as the therapist and acknowledges the therapist's human nature in the therapeutic relationship.

Special Populations: Substance Abusing Clients

Substance abusing individuals are regarded as one of the most difficult clients to treat due to the high level of behavioral problems, withdrawal symptoms, rude behavior,

constant crisis and challenges associated with the therapeutic relationship (Forrest, 2002; Weiss, 1994; Imhof et al., 1984; Najavits et al., 1995). Some practitioners may even avoid substance abuse treatment because of the level of difficulty and crisis associated with the alcoholic lifestyle (Imhof, Hirsch, & Terenzi, 1984).

Many substance-abusing persons enter treatment in psychological and physiological crisis, therefore managing client crisis effectively is important to the success of the individual (Forrest, 2002). Moreover, after stabilization occurs there is great possibility the client will experience further crisis, as this is expected with the level of problems persons seeking treatment experience. Financial constraints, housing problems, substance abusing peers, withdrawal, loss of friends or family, loss of employment, mental health problems, and relapse are all factors that can affect the client's emotional health and stability (Imhof, Hirsch, & Terenzi, 1984).

Treatment of a client with such varying forms of behavioral problems as well as types of crisis can easily fuel a countertransference reaction. In turn, this countertransference response can ultimately affect the client's success. For instance, the therapist who reacts by discharging a client from a program due to "rude" behavior would be engaging in a countertransference reaction to client behavior (Forrest, 2002). Moreover, transference itself can be blamed for client outcomes, rather than countertransference reactions on behalf of the therapist (Forrest, 2002). For example, the therapist who blames the client for inappropriate reactions to treatment standards is an example of the therapist blaming transference, rather than the professional

accommodating and treating the client for the behaviors for which they entered treatment (Teyber & McClure, 2011; Imhof et al., 1984; Forrest, 2002).

The most extensive account of countertransference reactions among therapists of substance abusers was developed by Weiss (1994). Weiss (1994) accounts for several factors that can cause countertransference among substance abuse professionals. These reactions are based on client behavior as the fuel for the countertransference reaction, and do not take into account *therapist-induced* countertransference. In this account the “alcoholic” is identified as unstable in their relationships with others and therefore projects this instability onto the therapist. As a result, anger is the most common reaction among treatment therapists as a countertransference response, and this often leads to rejection of the client. The therapist can also experience some anxiety related to a lack of control over the “alcoholic.” Weiss (1994) identifies several behaviors that fuel common countertransference such as, erratic attendance, concealing substance use, disregard for standards, grandiosity, repetition of speech, denial of illness, and continued drinking or substance use.

Countertransference reactions among professionals to substance abusing persons can ultimately result in “countertransference hate” as well as ambivalence toward the client (Weiss, 1994). Ambivalent behavior, or low motivation on behalf of the client, can also stimulate the therapist to react with “countertransference hate” toward a client. These types of reactions among professionals can significantly impact the therapeutic relationship if left unacknowledged or disregarded (Forrest, 2002; Weiss, 1994; Imhof et

al., 1984). Table 1 is a simplified chart taken from Weiss (1994) that outlines the common reactions of the therapist toward substance abusing client behavior.

Table 1

Client Behavior	Clinician Countertransference
Erratic attendance	Hurt, rejected
Concealing use, misrepresentation	Conned, confused, deceived, exploited, angry
Disregard for standards	Policeman, Angry, punitive, guilty, sadistic
Grandiosity, lack of affect	Bored, loss of interest, feeling shut out
Denial of illness, continued drinking	Hopeless, devalued, impotent as helper
Suicide attempts, frequent calls	Overwhelmed, drained
Seductive behavior, flattering therapist, idealizing treatment	Charmed, warmth, desires closeness, physical attraction, loss of boundaries
Failure to get medical care, high risk behavior	Panic, fears own reputation will be destroyed or client will be destroyed
Emphasizing pain, conveying helplessness	Sympathy and over concern, rescue fantasies, over responsible
Participation in treatment, AA, regular attendance, Genuine involvement	Positive regard, likes client, appropriate concern, genuine interest, feels hopeful

Common Countertransference reactions in alcoholic focused psychotherapy and related patient dynamics (Weiss, 1994, p. 414-415).

These are only a few examples of countertransference responses, as there are so many types of countertransference reactions among professionals that it is difficult to identify every type of countertransference reaction (Hofsess & Tracey, 2010). In addition to the therapist's countertransference, the substance abuse treatment field includes a large amount social stigma (Forrest, 2002). Even those who are therapists in the substance abuse field may be subject to professional stigma, meaning that those who are working in the substance abuse treatment field may be looked down upon, because they are treating some of societies most disliked persons (Forrest, 2002; Weiss, 1994). Ultimately, this negative perception can be projected on to agencies and as a result some programs may be under-funded, for instance, larger organizations may not invest emotionally and

financially into substance abuse programs within their organization. This projection is considered an example of the ways that agencies in general can be subject to countertransference reactions (Forrest, 2002; Weiss, 1994).

The Therapist's Response to Countertransference

Countertransference reactions toward a client can vary from positive loving feelings to anger and disdain. Additionally, these countertransference reactions can cause transference responses in the client, which can also have a varying impact on client behavior (Van Wagoner, Gelso, Hayes & Deimer, 1991). Van Wagoner et al. (1991) identify factors that reduced countertransference reactions among professionals. According to Van Wagoner et al. (1991), the characteristics of therapist's that allow therapists to manage countertransference reactions appropriately include: skill in management of anxiety, level of empathy, insight about one's own personal conflicts, skill in conceptualizing client dynamics and high personal integration (Van Wagoner et al., 1991). In addition to these characteristics some therapists also value supervision and ability to identify countertransference as a means in decreasing the therapist's impact on the client (Hofsess & Tracey, 2010). Most importantly therapist education pertaining to countertransference has been linked to client outcomes (Seiden et al., 1994). For example, after staff members of a substance abuse treatment program had been given additional training in countertransference, the success rates increased from 13% to 60% in the entry phase of treatment (Seiden et al., 1994). Moreover, the counselor's education or skill in managing countertransference may interfere with success in treatment, as a result the counselor may 'blame patients for failing to thrive in treatment', rather than the counselor

seeking supervision regarding a countertransference response (Weiss, 1994). As these characteristics increase the likelihood of a therapist having the knowledge and skill to manage countertransference reactions, it is therefore important to ensure the substance abuse therapeutic community is educated on countertransference. The state of Minnesota is regarded as one of the most prominent states in the treatment of substance abuse; however, it is unclear whether or not attention is given to countertransference reactions.

Conceptual Framework: The Minnesota Model of Treatment and Countertransference

Although the substance abusing individual is considered to be one of the most difficult individuals to treat, (Forrest, 2002; Weiss, 1994; Imhof et al., 1984; Najavits et al., 1995) prior to 2008, in the state of Minnesota, alcohol and drug counselors could receive a 2-year certificate in addiction counseling and be licensed to work as a therapist treating substance abuse disorders (Office of the Revisor of Statutes, 2010). Additionally, the addiction profession in Minnesota was founded on 12-step programs, group based therapy and recovering counselors as “counselors of choice” (Owen, 2002). In comparison, psychology and social work required, at the very least, a bachelor’s degree to practice. In response to this significant disparity, in 2008 the state of Minnesota changed this law (148C.04, Subd. 4) and required those seeking certification in addiction counseling to complete a bachelor’s degree (Office of the Revisor of Statutes, 2010). It is unclear whether or not this change in licensing has had any impact on therapeutic skill and client success rates, or if there was any problem with therapist skill prior to the addition in educational standards.

Rationale for Research and Hypothesis

For those in the substance abuse field, it is unclear what attention is given to education on countertransference. The State of Minnesota requires that “counseling theory” be part of addiction counseling education, but does not specify from what modality or types of counseling curriculum (Office of the Revisor of Statutes, 2010). If education on countertransference can possibly reduce countertransference reactions to client behavior and increase client success rates, it is therefore important to ensure education addressing countertransference is incorporated into education and training among substance abuse professionals. Therefore, this research aims to answer the questions: do therapists who are involved in addiction treatment have an understanding of countertransference? Are there differences between educational backgrounds such as addiction counselors in comparison to psychology or social work? Finally, does level of education also affect one's knowledge of countertransference?

It is hypothesized that those educated specifically with addiction counseling will have less knowledge of countertransference than those who were educated in social work, psychology, or marriage and family therapy. This hypothesis is based on previous license standards in the state of Minnesota, as those seeking a social work, psychology or marriage and family therapy license have been required to have at the very least bachelor's degree prior to 2008, and those working toward a degree in substance abuse had to obtain a 2-year certificate prior to 2008 (Office of the Revisor of Statutes, 2010).

Utilizing the prototype development of countertransference by Hofsess and Tracey (2010), this research intended to measure the understanding of

countertransference among professionals in the substance abuse field. A comparison will be made between licensed alcohol and drug counselors with an addiction specialty background and those in general psychology, social work or marriage and family therapy.

Method

Research Design

Hofsess and Tracey (2010) developed the prototype concept of countertransference. This concept was developed in an attempt to create an objectified measure of countertransference (Hofsess & Tracey, 2010). Prior to this development, most countertransference reactions were subjectively defined and significantly difficult to measure. A prototype is considered to be what one “typically” thinks of when a subject is discussed. For instance, if someone were to say the word “fruit”, it is highly likely that someone will think of an “apple” (Hofsess & Tracey, 2010).

This level of prototypical measurement on countertransference was developed by Hofsess and Tracey (2010) through a process where psychologists were asked to identify which concepts came to mind when they thought of countertransference. As a result of this process the prototypical concepts of countertransference were identified and incorporated as the Countertransference Measure (CM). This list of common countertransference reactions, the CM, included 104 items that did or did not meet prototypical countertransference reactions.

Hofsess and Tracy (2010) then asked psychologists to rate each item as countertransference or unrelated. As a result each item on the scale became labeled accordingly to prototype, peripheral or unrelated. For the items that did not make it into

the prototypical view of countertransference, these statements were labeled “peripheral” or “unrelated”. Peripheral examples were also rated from high to low on a scale, high being closer to a countertransference prototype and lower being closer to unrelated to countertransference. As each item was scored as “prototype”, “peripheral” or “unrelated”, each item resulted in a mean, therefore, the higher the mean, the more prototypical the item (Table 2). Validity for the Countertransference Measure was high, equaling .97.

The CM can be used to evaluate a practitioner’s knowledge of countertransference. For this research, the CM was used, and certain items were taken from the CM to measure countertransference knowledge among therapists from social work, psychology, marriage and family therapy or addiction specialty backgrounds.

The Countertransference Measurement tool (CM) developed by Hofsess and Tracey (2010) measured countertransference items in prototypical, unrelated and peripheral categories. Items were placed in these categories based on mean; the higher the mean, the more prototypical the item. Prototypical items selected from the CM for this research survey ranged between the Means of 6.44 and 5.18, from the original countertransference measure tool developed by Hofsess and Tracey (2010). The items selected were mid-range means and incorporated less prototypical items, but were still within the prototypical range. In comparison to the higher mean items of 7.0-6.76. Selecting mid range means may increase validity for the survey, as those items maintain a prototypical countertransference behavior, but are not so prototypical that any person would be able to identify them as countertransference. These means allow for clinical education to be taken into account. All items labeled “unrelated” were selected, since there were only 11 total.

Table 2

Items taken from the Countertransference Measure (CM) developed by Hofsess and Tracey (2010)

Countertransference Measure Item	Mean out of 7.0	Item Label
1. Rejects the client in session	6.44	Prototype
2. Treats the client in a punitive manner during session	6.42	Prototype
3. Engages in too much self disclosure	6.29	Prototype
4. Expresses hostility toward or about a client	6.22	Prototype
5. Acts in a submissive way with the client during session	5.93	Prototype
6. Is overly responsible for a client	5.93	Prototype
7. Dreads seeing a client	5.89	Prototype
8. Befriends the client in session	5.67	Prototype
9. Feels protective of a client	5.64	Prototype
10. Defends client in session or in supervision	5.60	Prototype
11. Expresses feelings of guilt to a client	5.60	Prototype
12. Significant discrepancies between case notes and what actually occurred in session	5.53	Prototype
13. Expresses feelings of envy to a client	5.51	Prototype
14. Does not bring up a client in supervision	5.51	Prototype
15. Expresses a need to be respected, appreciated and loved	5.47	Prototype
16. Acts defensive in supervision	5.44	Prototype
17. Expresses demands to help a client	5.44	Prototype
18. Avoids eye contact in session	5.42	Prototype
19. Rushes in to solve a client's problems	5.38	Prototype
20. Cherishes a client	5.38	Prototype
21. Departs from typical therapeutic style	5.33	Prototype

22. Behaves as if he or she were somewhere else during the session	5.31	Prototype
23. Is apathetic toward a client in session	5.29	Prototype
24. Feels hurt by something a client says or does in session	5.22	Prototype
25. Often sees things from the clients point of view	1.58	Unrelated
26. Reflects on a session with a client	1.32	Unrelated
27. Responds to a clients feelings	1.41	Unrelated
28. Recognizes his or her own negative feelings	1.61	Unrelated
29. Encourages a client to take appropriate risks	1.18	Unrelated
30. Is emotionally in tune with a client	1.36	Unrelated
31. Expresses empathy for a client loss	1.16	Unrelated
32. Is comfortable in the presence of strong affect from a client	1.34	Unrelated
33. Is prepared for supervision	1.17	Unrelated
34. Feels confident working with most clients	1.09	Unrelated
35. Understands the influence of culture in a client's life	1.64	Unrelated

Sample

Participants were selected through substance abuse treatment agencies in the St. Paul and Minneapolis, MN metro area. Five agencies were contacted and asked to complete an agency consent form; three agencies responded (Appendix A). The agency consent forms were signed and returned to the researcher. After consent had been established each agency received an anonymous link to the *Qualtrics* website to complete the survey. This link was distributed throughout the agency for staff members to complete the survey. There was no limitation on the number of participants within an

agency that could complete the survey. Participants were asked to have the following education and criteria:

- To be a working within a substance abuse agency of any kind, individual or agency based work.
- To have at least a 2 year associate's education in addiction, psychology, social work or marriage and family therapy.

Protection of Human Subjects

There were no risks or benefits associated with this research. Each participant was asked to sign an electronic consent form (Appendix B). This consent was obtained online through the use of the *Qualtrics* website. The first question of the survey obtained consent for participation and reviewed the benefits and risks associated with this research. Each participant had to select, *Yes I am willing to participate in this research* or *No I am not willing to participate in this research*. If the participant selected the term, *No I am not willing to participate in this research*, they were moved beyond the survey and not allowed to participate in the research. Data was obtained through anonymous completion of the survey, as the *Qualtrics* website allows for subjects to remain anonymous and have no IP address connected to their responses.

Recruitment Process

This survey was conducted and distributed through the use of an internet based questionnaire; utilizing the site *Qualtrics*. The website allowed for the anonymous completion of a survey as well as data gathering. A total of 5 agencies were contacted and 3 participated in the survey. Each agency was required to submit consent for participation in the research (Appendix A). Once each agency agreed to participate, an

anonymous survey link was emailed to the agency, where the site supervisors distributed this to the staff members. The name of the survey was *Countertransference and Substance Abuse Treatment*.

Data Collection

The survey consisted of 41 questions total, included in these questions were 35 items from the Countertransference Measurement tool (Hofsess & Tracey, 2010) (Appendix C). Participants were also asked the question: *I believe that I have a strong understanding of countertransference, and I have weekly supervision related to therapeutic intervention and managing countertransference issues*. The purpose of these two questions was to obtain the participants perception of countertransference, education and supervision. Participants were also asked their age, sex and how many years they have worked in the substance abuse field.

Participants were asked to identify which of the 35 items were examples of countertransference, using the responses of either *true or false*. Each item had a key of either prototype or unrelated for measurement later. The “prototypical” items were the items that closely resembled countertransference, where the items that were “unrelated” did not resemble countertransference. The “unrelated” items were included in the survey to add reliability and variability. Each item related to the countertransference measure was scored as 1 for correct or 0 for incorrect. The highest possible score was 35.

Results

In total there were 35 participants and a total of 3 agencies participated in this research. Although there were a total of 35 participants, only 29 fully completed the survey. The other 6 participants answered information pertaining to demographic data, years in practice, age of population served, identification of whether or not the participant receives supervision related to countertransference and perception of knowledge of countertransference. Upon completion of these answers the 6 participants did not complete the Countertransference Measure portion of the survey; therefore, their data was not used. A total of 29 participants were utilized to analyze data.

In total 8 participants were male and 21 were female (N=29). 18 participants were educated in addiction counseling, 8 psychology, 1 social work and 2 marriage and family therapy. In total 3 participants reported that they had obtained an associate's degree, 13 had obtained bachelors and 13 had obtained a masters degree (Table 3).

Table 3

Level of Education

	Frequency	Percent
AA	3	10.3
BA	13	44.8
MA	13	44.8
Total	29	100.0

Population served was divided into males, females or both. In total there were 4 participants that served female population alone, 3 worked directly with males and 22 with both genders. Population served was also analyzed according to adults and adolescents. 25 participants worked directly with adolescents, 4 worked directly with adults. Participant age was broken into 5 categories: 21-30; 31-40; 41-50; 51-60; 61-70. The largest category consisted of the age 21-30 with a total of 12 participants in that category (Table 4).

Table 4

Participant Age

Age	Frequency	Percent
21-30	12	41.4
31-40	8	27.6
41-50	6	20.7
51-60	1	3.4
61-70	2	6.9
Total	29	100.0

In response to the question “I have a good understanding of countertransference”, 27 replied that they thought they had a good understanding of countertransference and 3 reported that they felt they did not have a good understanding of countertransference (Table 5).

Table 5

Understanding of Countertransference

Response	Frequency	Percent
Yes	27	93.1
No	2	6.9
Total	29	100.0

In regards to the countertransference measure scores, the full range of scores varied between 10.0 correct and 32.00 correct. The mean score was 26.58. The variable of educational background was compared to the CM and participants scored the following: Addiction Counseling mean 26.55, psychology mean 26.00, social work mean score 25.00, marriage and family therapy mean score 30.00 (Table 6).

Table 6

Mean Scores of Educational Background

Educational Background	N	Mean
Addiction Counseling	18	26.5556
Psychology	8	26.0000
Social work	1	25.0000
Marriage and Family Therapy	2	30.0000
Total	29	26.5862

A one way analysis of variance (ANOVA) was conducted to analyze level of education in comparison to the countertransference measurement scale. Comparing AA, BA, MA levels of education to scores rated on the countertransference measure. Post Hoc

tests concluded that results were not significant, $p > .05$, $p = .261$, $df = 28$, $N = 29$. Therefore this research failed to reject the null hypothesis; level of education does not affect countertransference knowledge (Table 7).

Table 7

Level of Education and Countertransference Measure Score

	N	Mean	df	Sig.
AA	3	26.3333	28	.261
BA	13	25.3077		
MA	13	27.9231		
Total	29	26.5862		

In addition, level of education was separated into 2 categories, associate and all else (bachelors and masters). Level of education was compared to participant score on the countertransference measure. A t-test was utilized which concluded that there was no difference in countertransference knowledge according to educational level even when associates level education is compared to bachelors and masters level education combined $p = <.05$, $p = .515$.

One way analysis of variance (ANOVA) was also used to analyze educational background and countertransference measure score (CM). Results concluded that the difference in educational background did not affect participant score on the CM, $p = <.05$, $p = .647$. It was concluded that there was no relationship between type of educational background (psychology, social work, marriage and family therapy and addiction) and countertransference knowledge. To further analyze the relationship between educational background and knowledge of countertransference, educational

background was recoded into two categories: addiction counseling versus all else (Table 8).

This comparison of addiction counseling versus psychology, social work and marriage and family therapy did not conclude any significant results $p < .05$, $p = .075$. In total 18 participants identified a specialty in addiction and 11 identified themselves under psychology, social work or marriage and family therapy.

Table 8

Educational Background and CM Score

Background	N	Mean CM Score	Sig
Addiction	18	26.5556	.075
Psych/Social/ MFT	11	26.6364	

Age was also a variable compared to the countertransference measurement score. There was no significance regarding therapist age and countertransference knowledge, $p < .05$, $p = .135$.

A t-test was also utilized to evaluate the possible connection between belief in understanding of countertransference and actual countertransference measure score to evaluate relationship. No significant relationship was found between these two variables $p < .05$, $p = .233$. Therefore, participant's perception of understanding of countertransference was not connected to the actual score on the countertransference measure.

Population served was compared to the countertransference measurement scale. Most participants identified themselves working primarily with adolescents. An independent sample t-test was conducted to compare these variables and no significant relationship was found between countertransference score and age of population served, $p > .05$, $p = .778$ (Table 9).

Table 9

Age of Population and CM Score

Age of Population Served	N	Score Mean	Sig
Adolescents	25	26.7200	.778
Adults	4	25.7500	

Participant gender was analyzed in comparison to the CM score. There was no significant results, and it was concluded that participant gender did not affect one's score on the CM, $p < .05$; $p = .085$. In total there were 8 males and 21 females who completed the survey and CM (Table 10).

Table 10

Gender and CM Score

Gender	N	Mean	Sig
Male	8	24.2500	.085
Female	21	27.4762	

Finally, a Pearson correlation was conducted to identify if there is a relationship between one's years in practice and countertransference measure score. There was no significance in this relationship $r = .012$.

Discussion and Limitations

In the 1960's to the 1980's great emphasis was placed on analyzing and studying countertransference in substance abuse treatment. Today it is difficult to find literature reviewing the conjunction of these two concepts. Therefore, this study reviewed information pertaining countertransference and substance abuse counseling from literature 10 or more years ago. The most recent comprehensive account of countertransference and addiction therapy was written in 2002. This book, *Countertransference in Chemical Dependency Counseling* (Forrest, 2002), is largely a review of literature written decades before. Aside from this lack of current research, a recent study in 2003 found that there was very little research on specific client populations and countertransference.

Schwartz and Wendling (2003) reviewed 2 major search engines and retrieved only 14 articles related to special populations and countertransference, none of these articles had any connection to substance abuse. Due to this lack of current research on substance abuse treatment and countertransference, this research sought to increase awareness of countertransference and substance abuse treatment, as well as evaluate level of knowledge among professionals in the substance abuse treatment field.

The substance abuse treatment field in the state of Minnesota had recently increased professional licensing standards since 2008, requiring addiction counselors to seek certification at a bachelor's level (Office of the Revisor of Statutes, 2010). These results do not clarify if a change in licensing has increased one's ability to recognize countertransference. However, with these results, it is clear that in the state of Minnesota, we can conclude at the least, that some therapists, regardless of level of education or educational background have a similar understanding of countertransference concepts, meaning, that those specializing in addiction counseling are receiving training in countertransference concepts. This is good information since some research has identified substance abusing persons as a difficult population to treat (Forrest, 2002; Weiss, 1994; Saunders, Howard & Orlinsky 1989; Seiden, Chandler & Davis, 1994. Emphasizing the importance of this, Seiden et al., (1994) found that success in treatment can be affected by therapist knowledge of countertransference.

Although these results conclude that educational background and level of education were not factors in countertransference knowledge, the statistical analysis of these results could have been limited due to the number of participants. Moreover, some results brought forth some interesting considerations. For instance, educational background compared to countertransference knowledge was not statistically significant, yet when compared by addiction counseling versus all else, the results moved from $p < .05$, $p = .647$ to $p = .075$. Therefore, it could be that there are additional overlooked variables, such as, number of participants, place of employment or years in practice, when combined with educational background. Nevertheless, there remains variability in

educational background. In addition, although these were not significant results, when therapist gender and countertransference knowledge were compared, female therapists scored noticeably higher means than male therapists. And according to these results, years in practice was not a factor connected to countertransference knowledge.

Additionally, therapist's knowledge of countertransference was not varied by the age of the population served, and this research was largely connected to those working in adolescent substance abuse populations. It is unclear if these results would be similar if the population served would have included more adult than adolescent treatment programs. Minnesota is considered the "land of 10,000 treatment centers" and since only 3 agencies responded, it is also unclear if these results are actually generalizable to the substance abuse treatment population in Minnesota.

Another consideration is that this research was based on general countertransference concepts and was not directly measuring specific substance abuse countertransference reactions. Weiss (1994) had evaluated common countertransference reactions among substance abuse treatment professionals and this research did not include those countertransference responses, as they were not a part of the Countertransference Measure created by Hofsess and Tracey (2010). The countertransference experiences of therapists in substance abuse treatment may be different than what was measured. Another set of limitations with this study is that this research does not measure skill in therapeutic management of countertransference as it was intended to measure knowledge of countertransference concepts.

It is suggested that future research may want to pursue a larger sample size and utilize the entire Countertransference Measure created by Hofsess and Tracey (2010), since this research did not utilize the entire CM. Moreover, future researchers may want to create a Countertransference Measure based on substance abusing persons and utilize varied treatment populations based on age, social economic status, race or gender.

Finally, it was unfortunate to have only one clinical social worker as a participant in this study. It is unclear if this is an accurate representation of the amount of clinical social workers in the substance abuse treatment field. If so, it may be of value to emphasize the need for clinical social work in substance abuse treatment, as clinical social work values may be of benefit in the substance abuse treatment community. And future research may want to specifically compare clinical social work concepts of substance abuse treatment versus those specializing in addiction counseling, as the two educational trainings may vary according to therapeutic style.

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Appendix A

Agency Consent Form

I have authorized our agency, _____, to participate in this research. I have been informed of all aspects of this research. I am aware that involvement in this research will not affect my relationship or this agency's relationship with the University of St. Thomas. I am also aware that there are no risks or benefits associated with this research. Additionally, I understand that I will not have access to my employee's responses in this research as it is completely voluntary and confidential. Nor will I mandate my employees to engage in this research study if they do not wish to do so.

Signature

Appendix B

Electronic Consent Form

The purpose of completing this questionnaire is to obtain additional information on countertransference and substance abuse treatment. The decision to participate in this study is entirely voluntary. Although, your agency has been selected to take part in this research, it is not mandatory, nor will it have any effect on your employment. Your employer will not have access to your responses in this survey, nor will they be informed, unless you tell them, that you participated in the research. You may decide to end the survey at any time, by closing your internet browser.

The purpose of this study is to evaluate countertransference factors and substance abuse treatment. You will be asked a series of 45 questions related to countertransference. You will be asked to identify which items on the questionnaire you term as countertransference. In addition, certain demographics will also be asked such as age and sex. There are no risks or benefits associated with this research. All data will be kept confidential and remain in the custody of the main researcher, Samantha Yerks, until May 30, 2012. After this date all data will be deleted.

Appendix C

Survey Questions

The purpose of completing this questionnaire is to obtain additional information on countertransference and substance abuse treatment. The decision to participate in this study is entirely voluntary. Although, your agency has been selected to take part in this research, it is not mandatory, nor will it have any effect on your employment. Your employer will not have access to your responses in this survey, nor will they be informed, unless you tell them, that you participated in the research. You may decide to end the survey at any time, by closing your internet browser.

The purpose of this study is to evaluate countertransference factors and substance abuse treatment. You will be asked a series of 45 questions related to countertransference. You will be asked to identify which items on the questionnaire you term as countertransference. In addition, certain demographics will also be asked such as age and sex. There are no risks or benefits associated with this research. All data will be kept confidential and remain in the custody of the main researcher, Samantha Yerks, until May 30, 2012. After this date all data will be deleted.

I have read the above statement and agree to participate in this research

I have read the above statement and do not agree to participate in this research

Appendix C

1. I have at least a 2 year background in one of these 3 fields: Please Select one:

Social Work

Psychology

Marriage and Family Therapy

Addiction Counseling

2. My Highest Level of Education is:

AA BA MA PHD

3. Age of Population Served

Adolescent

Adult

4. Gender of population Served:

Male

Female

Both

5. Please Identify yourself in terms of Age_____

6. Please Identify yourself in terms of gender:

Male

Female

7. I have a good understanding of countertransference:

Strongly agree/ Agree/ Disagree/ Strongly Disagree

8. I have been in the substance abuse treatment field for _____ years

Appendix C

9. I have supervision related to therapeutic intervention and managing countertransference issues:

Yes

No

10. The following statements reflect countertransference: True or False

- T/F Rejects the client in session
- T/F Treats client in a punitive manner
- T/F Engages in too much self disclosure
- T/F Expresses hostility toward or about a client
- T/F Acts in a submissive way with the client during session
- T/F Is overly responsible for a client
- T/F Dreads seeing a client
- T/F Befriends the client in session
- T/F Feels protective of a client
- T/F Defends client in session or in supervision
- T/F Expresses feelings of guilt to a client
- T/F Significant discrepancies between case notes and what actually occurred in session
- T/F Expresses feelings of envy to a client
- T/F Does not bring up a client in supervision
- T/F Expresses a need to be respected, appreciated and loved
- T/f Acts defensive in supervision
- T/F Expresses demands to help a client
- T/f Avoids eye contact in session
- T/F Rushes in to solve a client's problems
- T/F Cherishes a client
- T/F Departs from typical therapeutic style
- T/F Behaves as if he or she were somewhere else during the session
- T/F Is apathetic toward a client in session
- T/F Feels hurt by something a client says or does in session
- T/F Often sees things from the clients point of view

- T/F Reflects on a session with a client
- T/F Responds to a clients feelings
- T/F Recognizes his or her own negative feelings
- T/F Encourages a client to take appropriate risks
- T/F Is emotionally in tune with a client

Appendix C

- T/F Expresses empathy for a client loss
- T/F Is comfortable in the presence of strong affect from a client
- T/F Is prepared for supervision
- T/F Feels confident working with most clients
- T/F Understands the influence of culture in a clients life