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Chemical Dependency Counselors' Perceived Countertransference and its Relationship to Personal Experience With Substance Use

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Chemical Dependency Counselors' Perceived Countertransference and its Relationship to
Personal Experience with Substance Use

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Abstract

The current study explores the relationship between countertransference and the chemical dependency counselor's experience with substance use disorders, through personal use, family member substance use, or a close friend's struggle with drug use. LMHC, LCSW, LMSW, and CASAC credentialed individuals were given a countertransference survey which also included questions about personal substance use history. Eight participants completed and returned the survey. Results showed that a significant relationship does exist between at least one countertransference survey item and each category of substance use history that included personal use, parent use, another immediate family member use, extended family member use, and close friend use. The findings of a significant relationship indicate the impact counselor substance history has on countertransference in chemical dependency treatment and the importance of counselors becoming more self aware in order to provide the most effective treatment possible.

Chemical Dependency Counselors' Perceived Countertransference and its Relationship to Personal Experience with Substance Abuse

Substance abuse and dependence are prominent issues in today's society (Substance Abuse and Mental Health Services Administration, 2011). Chemical dependency counselors may have experience in their personal lives with substance-related disorders, which may contribute to countertransference in counseling (Culbreth, 2000). The purpose of the current study is improving the quality of counseling services to chemical dependency clients by helping chemical dependency counselors who have a history with substance use to prevent countertransference.

The relationship between the substance abuse counselor's recovery status and client treatment outcome establishes the importance of the current research study. Past experience of substance use and treatment may contribute to countertransference within counseling sessions (Oser, Biebel, Pullen, and Harp, 2011). The current research is focused on identifying any significant relationship between countertransference and the substance abuse counselor's personal history with substance use, whether it is personal recovery or experiencing substance use through family members or close friends. Substance abuse counselors in this study included Licensed Mental Health Counselors, licensed social workers, and individuals who are Credentialed Alcoholism and Substance Abuse Counselors (CASAC).

In order to understand the rationale of the current study, it is important to understand the impact of substance use on individuals and communities. This study is important in order to research and understand the impact countertransference has on client treatment outcome (Culbreth, 2000).

The study addresses the question, is there a relationship between countertransference and a chemical dependency counselor's personal experience with substance use, whether it be through personal use or experiencing a family member, or close friend, struggle with substance use? Chapter 1, the Literature Review, provides background into the definition and relevance of substance use disorders and countertransference in chemical dependency treatment. Chapter 2, Method, reports the study is conducted at a chemical dependency outpatient clinic, with eight participants completing a countertransference survey. In chapter 3, Results, the data collected are analyzed using independent t-tests in order to identify a significant relationship among the variables - countertransference and substance use history. Chapter 4, Discussion, emphasizes the importance of counselors being self aware of countertransference and the impact it has on client treatment

Review of the Literature

Substance abuse and dependence related disorders appear to impact a number of communities and have multiple effects on the population. The research below defines substance related disorders, illustrates the effects of these disorders, and provides examples of how these disorders can impact an individual or community. Due to the impact of substance use disorders, there is a need for chemical dependency counselors within a community. Some chemical dependency counselors may have personal experience with substance abuse, which may impact relationships with clients in treatment (Culbreth, 2000). The research below indicates how past experiences can affect treatment outcome through countertransference. Different settings and approaches of treating substance use disorders create different dynamics among counselors and clients in which countertransference can occur. The focus of this study is to research and

understand how counselors perceive the impact of personal substance use history on treatment outcome.

According to the 2010 National Survey on Drug Use and Health (NSDUH, 2011), originating from the Substance Abuse and Mental Health Services Administration (SAMHSA), it was estimated that 8.9% of the population, ages 12 and older, were current illicit drug users; and 51.8% of the population, ages 12 and older, were current alcohol users. Approximately 67,500 people in the United States, ages 12 and older, were interviewed for the NSDUH (SAMHSA, 2011). According to the 2010 NSDUH, an estimated 8.7% of the population, ages 12 and older, were classified as having a substance abuse or dependence disorder, according to the criteria listed in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV, 2000; SAMHSA, 2011). Out of the 8.7 % of the population diagnosed with a substance abuse or dependence disorder, 2.9 million were diagnosed with substance abuse or dependence of both illicit drugs and alcohol (SAMHSA, 2011). The specific illicit drugs that are most prevalent in substance abuse and dependence diagnosis are: marijuana, pain relievers, and cocaine (SAMHSA, 2011).

Some substance abuse counselors are identified as being in recovery, meaning they have dealt with personal substance abuse or dependence of their own in the past. Some substance abuse counselors may also have experienced family members or close friends living with substance abuse or dependence (Martino, Nich, Frankforter, & Carroll, 2009). Personal experience with substance abuse may interfere with providing treatment due to countertransference, the psychological transferring of feelings from counselor to client during the course of treatment (Jones, 2005). The current study focuses on the substance abuse counselor's

personal history dealing with substance abuse or dependence and if there is a relationship of personal history with countertransference in counseling sessions.

Defining Substance-Related Disorders

According to the DSM-IV-TR, substance-related disorders are defined as “disorders related to the taking of a drug, to the side effects of a medication, and to toxin exposure (American Psychiatric Association [APA], 2000, p.191).” The substances referred to in the DSM-IV-TR are divided into eleven categories; alcohol, amphetamines, caffeine, cannabis, cocaine, hallucinogens, inhalants, nicotine, opioids, arlycyclohexylamines, and sedatives, hypnotics, and anxiolytics. For the purpose of the study, substance abuse and substance dependence are the main substance-related disorders identified. Substance abuse is defined in the DSM-IV-TR as “a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances” (APA, 2000, p.198). Substance dependence is defined in the DSM-IV-TR as “a cluster of cognitive, behavioral, and psychological symptoms indicating that the individual continues use of the substance despite significant substance-related problems” (APA, 2000, p.192).

Effects of Substance Abuse and Dependence

Substance use disorders can lead to many adverse consequences, including mental and physical health problems, relationship problems, financial problems, and legal problems (Brody, Yu, Chen, Kogan, & Smith, 2011). According to the National Institute on Drug Abuse (NIDA, 2012), chronic substance use can lead to long term or permanent changes in the brain, which can cause mental health issues such as paranoia, depression, and hallucinations. Studies show that approximately half of individuals who suffer from a severe mental health disorder also have had

a substance use disorder at some point in their lives, if not currently (Butler, Indig, Allnutt, & Mamoon, 2011).

Medical. Substance use can result in immediate and long-term health problems (NIDA, 2012). Long-term medical consequences to substance abuse include strokes, cancer, cardiovascular disease, HIV/AIDS, hepatitis, lung disease, and death. Some medical consequences of substance use can occur from long term use, a high dosage, or some might even occur after a single use. A study conducted in the Netherlands (Krul, Blankers, & Girbes, 2011), identified some health problems caused by substance use that required immediate medical attention. The researchers collected information from 249 rave parties, over a 12-year span, identifying substance related cases that required immediate professional medical care, including fevers, cramps, palpitations, stomachaches, airway threats, and hypothermia.

Legal. Legal problems are also associated with substance abuse and dependence. Some theorists believe crime causes substance abuse and others believe that substance abuse causes crime (Walters, 2012). According to Walters, over half the offender population has a history of substance abuse or dependence. Beck (as cited in Phillips, 2010) reported over 73% of individuals in the criminal justice system population have a connection of substance abuse to their criminal behaviors. Individuals with substance use disorders are likely to re-offend and get back into the criminal justice system, due to relapse or difficulty finding treatment (Phillips, 2010). Research conducted by Phillips included interviews with 20 incarcerated men who had been incarcerated at least once before. All the men in the study identified substance abuse as the main reason for their criminal history. Fifteen of the 20 men attributed their return to prison to drugs and their uses. Other than incarceration, other forms of legal consequences due to substance abuse include parole, probation, and drug court.

Drug court is a program for individuals with drug offenses that is based on completing treatment and connecting with resources to succeed at staying clean from substance use (Cooper, 2007). Drug court is a highly structured program and certain criteria need to be met before successful completion, such as obtaining a GED (Cooper, 2007). Drug court is considered a more therapeutic approach for the treatment of substance use disorders, as opposed to incarceration, and is intended to prevent future drug related offenses. According to Cooper, drug court focuses on the physiological effects of substance related offenses as well as the criminal offense, by providing an opportunity for the substance user to rebuild one's life. Even after completing drug court programs and turning their lives around, individuals with drug offenses may still experience consequences, such as not receiving all benefits from public housing, welfare, educational benefits, or voting rights due to their drug related charges (Cooper, 2007). Other legal implications for drug related charges include large fines, loss of driver's license for multiple months to years, probation, and being sentenced to jail or prison for varying lengths of time (Phillips, 2010).

Financial. Financial problems can also result from substance use. Job loss, or the inability to obtain a job, is common among chronic substance users (Eyrich-Garg, Cacciola, Carise, Lynch, & McLellan, 2008). Ritters and Chalmers (2011) argued that the struggle to obtain a job may result in increased drug use due to idle time or as a means to cope with the stress of looking for a job. Financial problems associated with substance abuse can lead to homelessness. According to Eyrich-Garg et al., on any given night in the United States, over 2% of the population may be homeless; substance use is a large contributing factor to homelessness, followed by mental and physical health problems and legal issues.

Relationships. Personal relationships can also suffer from substance abuse or dependence, whether it is parent-child relationships, friendships, or intimate relationships (Brody, et al., 2011). Substance abuse can affect many people and many relationships in one person's life, not just the individual using substances. Oftentimes, family members and friends of substance using individuals experience disruptions in their lives including marital distress, social problems, financial problems, aggression, and interpersonal violence (Roozen, Waart, & van der Kroft, 2010).

Treatment Settings

Individuals diagnosed with a substance use disorder can receive treatment from different types of facilities, including inpatient hospital settings, outpatient rehabilitation clinics, residential settings, self-help groups, emergency rooms, primary care physicians, prisons or jails, and mental health centers (SAMHSA, 2011). According to the 2010 NSDUH, 9.1% of the United States population, ages 12 and older, needed treatment for alcohol or drug use (SAMHSA, 2011). Out of the 9.1% needing treatment, only 1% received treatment at a *specialty facility* for chemical dependency.

Self-help. Self-help groups were recognized as aiding the largest number of people with substance use disorders (SAMHSA, 2011). The most prevalent self-help groups include, Alcoholics Anonymous (AA), and Narcotics Anonymous (NA), and are based on a 12-step model (Bonn-Miller, Zvolensky, & Moos, 2011). Self-help meetings are usually one to two hours long and consist of guest speakers and a group discussion among those in attendance (Doyle, 1997). Self-help groups focus mainly on the goal of abstinence from substance use and provide regular support for individuals who may be involved in a different form of treatment,

such as an outpatient clinic. Self-help groups are also for individuals who have completed treatment but want to continue to have a sober support network (Bonn-Miller et al., 2011).

Specialty facilities. Treatment for substance use disorders can also be received from specialty outpatient or inpatient facilities. A *specialty facility* is defined as an inpatient or outpatient setting, or a mental health center, where the main focus of treatment is substance use disorders (SAMHSA, 2011). Outpatient services include groups, individual sessions, medical, and mental health care based on daily or weekly appointments to work through substance use along with additional problems the individual may be experiencing (SAMHSA, 2011). Inpatient service is a treatment process where clients receive 24 hour care for their substance use disorder, mental health problems, and medical issues. Inpatient service also provide intensive detoxification services (SAMHSA, 2011).

Medical treatment. Individuals who abuse substances can also receive treatment from one's primary care physician who are able to treat withdrawal symptoms with certain types of medication (SAMHSA, 2011). Serious substance use related emergencies can be treated at hospital emergency departments, such as substance related accidents or serious reactions to a substance.

Criminal justice. Individuals incarcerated for a drug offense are also provided substance use treatment services in prison or jail (SAMHSA, 2011). Drug treatment studies have shown that for incarcerated individuals substance abuse treatment reduces relapse, criminal behavior, recidivism, and misconduct while incarcerated. Treatment provides incarcerated individuals the chance to develop coping skills for mental illness and behavioral disorders. Research shows that treatment increases positive outcomes when individuals receiving treatment return to their communities (Federal Bureau of Prisons, 2012). The treatment provided to incarcerated

individuals include, drug abuse education as well as residential and non-residential treatment programs that provide cognitive behavioral therapy. The treatment programs work with individuals on rational thinking, recognizing their criminal lifestyles, and communication building (Federal Bureau of Prisons, 2012). Another treatment program provided is the Community Transition Drug Abuse Treatment, which aims to provide individuals with skills to make a successful transition back into society and to help prevent return to prison (Federal Bureau of Prisons, 2012).

Treatment Approaches

Within the different settings for treatment for substance use disorders, there are also different approaches towards providing treatment for individuals. Each of the following treatment approaches focus on social support, including: community reinforcement, gender specific, and family training approaches.

Community reinforcement approach. The Community Reinforcement Approach (CRA) is an example of substance abuse and dependence treatment (Siporin & Baron, 2010). CRA includes a variety of modalities, such as behavior therapy, stress management, medication, motivational therapy, and job skills training (Siporin & Baron, 2010). The CRA encourages sober social and recreational activities that lead to a rewarding sober life. Counselors and staff organize non-drug recreational activities offered at discounted prices so clients may be able to enjoy activities without using substances (Siporin & Baron, 2010).

Gender specific approaches. Another example of an intervention in substance abuse and dependence treatment is gender specific treatment, specifically designed to increase treatment benefits for women (Linton, Flaim, Deuschle & Larrier, 2009). According to Linton et al. (2009), women have different issues than men, including the importance of group communication,

relational aspects of substance use, assessment of trauma history, parenting issues, women specific health related issues, and assessment of co-occurring mental health disorders.

Addressing the aforementioned issues in substance abuse treatment is believed to improve outcomes. A qualitative study (Linton et al., 2009) focused on a holistic theory approach to include all aspects of client's lives to receive the most effective treatment as possible. The study conducted by Linton et al., consisted of 23 women participants in a focus group who were enrolled in an aftercare treatment program at a chemical dependency agency (2009). Three focus group interviews were conducted to collect information about the participants' perceptions of the substance abuse treatment setting and the services offered (Linton et al., 2009). The women participating in the focus group identified that the gender-specific treatment program focused on their feelings of empowerment and having the feeling of safety and comfort to work towards self discovery and personal growth (Linton et al., 2009). Women participating in the focus groups also identified the holistic services in their treatment program to be very beneficial to their recovery and noted that they would have liked more opportunity for holistic services (Linton et al., 2009).

Community reinforcement and family training. Another form of treatment is to involve family members in the recovery process. Roozen et al. (2010) discussed the Community Reinforcement and Family Training (CRAFT) program, which involves engaging a treatment resistant individual by working with family members, significant others, and friends. Programs involving the substance using individual and their loved ones focus on the treatment of everyone who is affected by substance abuse (Roozen, et al., 2010).

Support for family and friends. Family members and friends of substance abusers have self-help groups, such as Al-Anon meetings, to offer support and help individuals through the

treatment process of their loved ones (Keinz, Schwartz, Trench, & Houlihan, 1995). The emphasis of programs, such as Al-Anon meetings, is to support family and friends of substance users and to help change their attitudes on how to deal with a substance use disorder (Keinz et al., 1995). Self-help groups for family members and friends stress the need for change in their lives and offer programs assisting with those positive changes and the recovery of their loved one (Keinz et al., 1995). Many family members and friends, of individuals with substance use disorders, need their own physical and mental health treatment to cope with the substance using individual and the effects substance abuse has on their daily lives (Roizen et al., 2010). Keinz et al. (1995) conducted a research study to identify the effectiveness of self-help groups for family and friends of individuals with use. The researchers distributed surveys to members of three different Al-Anon meetings and found that many Al-Anon members partner's uses created disruptions in their marriages. The study showed a significant correlation between increased length of membership to an Al-Anon program and increased self-esteem and improvement of marital relationships.

Treatment Providers

Treatment for substance use disorders is provided in a variety of different settings and by a variety of different professions, including social workers, licensed professional counselors, certified counselors, physicians, and nurses (Rieckmann, Farentinos, Tillotson, Kocarnik & McCarty, 2011). The diversity among professionals providing chemical dependency treatment allows for a collaboration of different experience, different training, and different theoretical backgrounds (Rieckmann, et al., 2011). The professionals providing substance abuse treatment should be prepared to work with substance abuse issues through their training in the knowledge of theories of use and knowledge of the social, economic, and cultural context in which

substance abuse and dependency exists (OASAS, 2012). Professionals providing substance abuse treatment are supposed to be trained in assessing and evaluating substance use disorders, as well as, training in the philosophies and practices of models of treatment, recovery, relapse prevention, and the continuation of care of substance abuse and dependence issues (OASAS, 2012).

Attitudes toward Substance Use Disorders

Reports show that professionals are likely to have negative attitudes toward counseling clients diagnosed with a substance use disorder. Negative attitudes may impact effectiveness of substance abuse and dependence treatment provided to a client (Rodgers-Bonaccorsy, 2010). Certain types of substances, such as heroin, have been found as a possible reason for negative attitudes toward substance use disorders (Howard & Holmshaw, 2010). Also lack of training in counseling individuals diagnosed with a substance use disorder was also identified as a reason for negative attitudes toward substance use (Howard & Holmshaw, 2010). Lack of the therapist's confidence to identify and treat substance abuse disorders may lead to negative attitudes toward clients with substance abuse issues (Rodgers-Bonaccorsy, 2010). Silins, Conigrave, Rakvin, Dobbins, and Curry (2007) conducted a study with graduate students and provided them with twenty-one questions from the Alcohol and Alcohol Problems Perception Questionnaire. First-year graduate students expressed a more negative attitude towards substance use than fourth-year graduate students; the researchers suggested that the difference was due to the educational and training differences between students (Silins, et al., 2007). Howard and Holmshaw (2010) conducted a study using the Drug and Drugs Problems Perceptions Questionnaire (DDPPQ) and found that professionals, with more training, indicated having less negative attitudes toward substance use disorders. More training is identified as having a degree or license in counseling or

social work and also training specific to substance abuse issues (Howard & Holmshaw, 2010), such as having the knowledge of use and the knowledge to assess and evaluate individuals with substance use disorders (OASAS, 2012). Individuals trained in the models of treatment, recovery, and relapse prevention also have less negative attitudes toward substance use (Howard & Holmshaw, 2010). Rodgers-Bonaccorsy (2010) also found that a lack of training was related to negative attitudes towards substance use disorders.

Impact of Past Experience in Present Situations

Past experience in a person's life can affect feelings, emotions and behaviors in present situations (Tykocinski & Ortmann, 2011). According to Koslowsky, Solomon, Bleich, and Laor (1996), exposure to stressful events can result in intrusion and avoidance as coping behavior. They defined *intrusion* as thoughts, feelings, and images related to the stressful past experience. *Avoidance* was defined as conscious denial of feelings and ideas, and avoiding certain situations related to the stressful past experience. Stressful past experiences may also result in diminished ability to cope with challenging situations in the present (Nakajima & Muto, 2006).

According to Nakajima and Muto (2006), past experiences can be a direct guide of how people live their lives. Nakajima and Muto's study examined the application of compensatory secondary control (CSC) and how it can promote more positive control over emotions and reactions in the present related to past adverse experiences. CSC is defined as "an adaptive cognitive strategy in which the individual adjusts emotions and motivations in response to experiences of the external environment" (Nakajima & Muto, 2006, p.46). According to Nakajima and Muto, it is how people cope with past events that is linked to their perception, whether it be positive or negative, of their current situations and their control over those situations.

Transference and countertransference. Transference is an unconscious redirection of feelings and experiences from the past into current situations (Jones, 2005). Patterns of relationships from the past may be repeated due to transference and may be inappropriate for the present situation. Sigmund Freud first used the term transference to describe how clients project certain feelings from previous experiences onto their current therapist (Lambert, 1972). Transference may be positive or negative (Jones, 2005). Positive transference may result in feelings of love, admiration, and being overly receptive of another person's suggestions. Negative transference may result in feelings of mistrust and hostility (Jones, 2005) and may hinder the therapeutic process and harm the understanding between client and counselor (Heimann, 1960). Transference may be triggered by a specific characteristic of a person or setting and may have little relevance to the current situation. In the same way, countertransference is the psychological transferring of feelings from counselor to client during the course of treatment. Countertransference is the counselor's specific thoughts, feelings, and attitudes toward specific characteristics of a client or situation (Jones, 2005). Examples of specific characteristics might include similarities of client and a past relationship in the counselor's life or similar life experiences between counselor and client.

Countertransference is often times outside of the counselor's awareness and can be harmful to the therapeutic relationship (Purcell, 2003). Countertransference can create a powerful love or a powerful hate within the client and counselor relationship. Countertransference may also result in a distortion of interpretation of the client's situation (Jones, 2005). Even if the counselor is not aware of his or her feelings of countertransference, clients may experience the impact of countertransference within treatment (Purcell, 2003). Clients may not be provided with the best treatment possible and may or may not be aware of it.

Counselor self awareness is essential to keep countertransference from negatively affecting the therapeutic relationship (Purcell, 2003). Counselors may not understand their reactions to certain characteristics and experiences in their clients, but once they become aware of their reactions the counselor can begin to work through his or her own feelings. Even the most educated and self-aware counselors can experience countertransference with a client. Supervision, consultation, and education will provide the counselor with a way to work through their reactions to certain situations (Purcell, 2003). Once feelings of countertransference are recognized and worked through, it is possible for those feelings to be used constructively in treatment. In some cases, to prevent harm to the client, the client can be referred to another counselor (Purcell, 2003).

A study was conducted by Betan, Heim, Conklin, and Westen (2005) to measure countertransference among 181 psychiatrists and psychologists. A 79-item countertransference questionnaire was given to the participants to measure a wide range of behaviors, thoughts, and feelings expressed by therapists to their clients in regards to personality disorders (Betan et al., 2005). The countertransference questionnaire was broken into eight factors: overwhelmed/disorganized, helpless/inadequate, positive, special/over involved, sexualized, disengaged, parental/protective, and criticized/mistreated (Betan et al., 2005). The results showed that an overwhelmed/disorganized countertransference pattern was common towards clients with personality disorders (Betan et al., 2005). The study also suggests that understanding the different factors of countertransference can be useful for counselors to understand the client's dynamics and interpersonal patterns (Betan et al., 2005). The study shows the importance of counselor self-awareness in order for countertransference not to harm the therapeutic relationship (Betan et al., 2005).

Chemical abuse and dependence histories of substance abuse counselors. Substance abuse counselors may have experienced substance use disorders in their history, whether it be from personal use or being affected by a family member or close friend struggling with a substance use disorder. According to the 1994 membership of the National Association of Alcoholism and Drug Abuse Counselors ([NAADAC] as cited in Doyle 1997), 58% of members were in recovery from a substance use. According to Martino et al. (2009), substance abuse counselors in recovery have an edge in rapport building because of shared experiences, as compared to counselors not in recovery. A strong relationship can form between counselors in recovery and clients due to the understanding the counselor has of the recovery process (Martino et al., 2009). According to Culbreth, however, no significant differences have been found in treatment outcomes for clients with a substance use disorder based on the counselor's recovery status (2000).

Therapeutic techniques used in counseling sessions or how substance use is viewed may be different among counselors in recovery versus counselors not in recovery (Culbreth, 2000). A research study conducted by Oser et al. (2011), collected data from focus groups involving twenty-eight substance abuse counselors in which recovery status was discussed. Many counselors believed that counselors in recovery had a less difficult time establishing rapport with clients. Many agreed, however, that if clients state that they cannot connect with their counselor who has not been in recovery, that it is an excuse to not follow through with the treatment process. Substance abuse counselors discussed the importance of having counselors in recovery and having counselors who have the education and know about living a substance free life. The focus group participants stated that having a diversity of recovery status among counselors in an agency was important

Substance abuse counselors in recovery can, however, raise concerns about counselors being involved in dual relationships (Doyle, 1997). A dual relationship is when a professional counselor assumes two roles with a client, either both roles concurrently or consecutively (Doyle, 1997). The ACA Code of Ethics (2005) states that any nonprofessional interaction with a current or former client, or a family member of a client should be avoided, unless it has the potential to benefit the client. One example of a dual relationship that may arise is when a counselor and a current, or former, client attend the same self-help meeting. Attending the same meeting may put the confidentiality of the client and the anonymity of the counselor at risk (Doyle, 1997). Also a counselor may not be fully open in disclosing at a self-help meeting which may result in weakening the counselor's own recovery program. Counselors' past experience with substance use may result in certain behaviors, thoughts, and feelings toward clients in substance abuse treatment. Countertransference may be present in counseling sessions due to personal substance use history. The current study identifies that relationship between personal substance use history and countertransference.

Method

The research design utilized is a t-test to identify relationships between countertransference, as the dependent variable, and the chemical dependency counselor's personal history with substance abuse/dependency, as the nominal independent variable. There are multiple independent variables within substance abuse history: a counselor's own recovery, experience with a parent with use, experience with another immediate family member with use, experience with an extended family member with use, and experience with a close friend with use. The following section identifies the setting, participants, instrument, and procedure used to collect data needed to answer the current research question.

Setting and Participants

The study was conducted in a chemical dependency outpatient clinic. The outpatient clinic is part of a larger community agency that services children, families, and adults in upstate New York. The chemical dependency outpatient clinic where the study was conducted provides substance abuse and mental health treatment for males and females 18 years and older.

Participants of the study were recruited, through use of a letter (see appendix A), as a convenience sample within the chemical dependency outpatient clinic. A convenience sample was utilized as it was conducive to the researcher's graduate internship and availability of the counselors at the clinic. Individuals who were invited to participate in the study included 36 male and female therapists who were Licensed Mental Health Counselors, Licensed Master Social Workers, Licensed Clinical Social Workers, and individuals who were CASAC (Credentialed Alcoholism and Substance Abuse Counselor) credentialed. The therapists were given information about the current study in a cover letter (see appendix B) and a letter of informed consent (see appendix C). Participants were kept anonymous by having no identifying information on the survey. No compensation was offered for participating in the study.

Instrument

Participants were asked to complete a 91-question survey (see appendix D). The survey included the 79-item questionnaire entitled "Therapist Response Counter Transference Questionnaire" available for public use from the Emory University website, <http://www.psychsystems.net/Manuals>. The questionnaire uses a Likert-type rating scale to identify relevance of the countertransference items, ranging from "not true at all" to "very true." Questions added to the survey included an item about why the participant chose a particular client to think about while taking the survey and a question about the client's readiness for

change. The survey also included demographic questions to identify personal experience with substance abuse, using a nominal rating scale of “yes” or “no.” The survey was selected for the current study because it focuses on the participating counselor’s physical and emotional responses to a particular client.

Procedure

Participants were given a recruitment letter in their agency mailboxes, explaining the purpose of the study and explaining that participation is completely voluntary. After distributing the recruitment letter, a packet was given to participants in their agency mailboxes that included a cover letter explaining the purpose of the study, a letter of informed consent which explained potential risks, and the Therapist Response Counter Transference Questionnaire. Completed surveys were dropped into a locked box in the employee locked mailroom, with only the principal investigator having access to the key of the locked box. Surveys were collected from the locked box each day by the principal investigator and were kept in a locked drawer with only the principal investigator having access to the locked drawer. At the completion of the research study all surveys were destroyed through shredding of the documents.

Data Analysis

Survey results were analyzed through the SPSS program. Independent t-tests were run to identify relationships between counter transference and the independent variables of substance abuse experience in the participant’s personal history. No additional inferential tests were done as the results from the independent t-tests were sufficient for the purpose of this study.

Results

The present study was conducted to determine a relationship between countertransference and the chemical dependency counselor's personal experiences with substance abuse. It was hypothesized that a relationship exists between countertransference and the chemical dependency counselor's experience with substance abuse, whether it be through personal recovery or through a friend or family member's substance abuse. The nominal, yes-no independent variables in this study included substance abuse history experiences and the dependent variable was countertransference. Substance abuse history is defined as the participant having personal substance abuse recovery experience or experiencing substance abuse struggles through a parent, an immediate family member, an extended family member, or a close friend. Out of 36 surveys distributed to licensed social workers, licensed mental health counselors, and CASAC credentialed counselors at a substance abuse counseling program, eight surveys were completed and returned.

Participants were asked to identify the most challenging client to work with when completing the survey. Three participants chose "The client's attitude toward treatment" as the reason for choosing a particular client to think of while completing the survey. Two participants chose "Behavioral issues with client," and two participants chose "Client's mental health diagnosis." One participant chose "The client's attitude toward treatment" and "Behavioral issues with client" as reasons for identifying the most challenging client. None of the participants chose "Demographic differences between you and the client," and "Other" as reasons that a particular client was challenging.

Two participants were treated for drug and alcohol use. One participant identified having a parent in treatment for substance abuse, while two participants indicated having a parent diagnosed with a substance abuse disorder. Four participants indicated having another immediate family member diagnosed and having gone through treatment for substance abuse. Four participants reported having an extended family member in treatment for substance abuse, and five participants stated having an extended family member diagnosed with a substance abuse disorder. Six participants indicated having a close friend diagnosed with and being in treatment for substance abuse.

Independent samples t-tests were used to analyze each item of substance abuse history, the independent variables, in relation to all the countertransference items on the survey, the dependent variables. Each independent variable showed a significant relationship with one or more of the countertransference items on the survey.

The following table shows the significant relationships found between the independent variables (IV) and dependent variables (DV). An independent samples t-test was used to analyze mean difference in countertransference for each independent variable.

Table: Independent Samples T-test for Mean Differences for Countertransference

Variables	T-Test	DF	P-Value*	DV Mean Difference
<i>I've been in treatment for alcohol abuse (IV)</i> Overwhelmed by his/her strong emotions (DV)	3.031	6	.023	2.33

Variables	T-Test	DF	P-Value*	DV Mean Difference
He/She stirs up strong feelings (DV)	3.464	5	.013	1.33
<i>I've been in treatment for drug abuse (IV)</i>	3.031	6	.023	2.33
Overwhelmed by his/her strong emotions (DV)	3.464	5	.013	1.33
He/She stirs up strong feelings (DV)				
<i>One of my parents has been in treatment for substance use (IV)</i>				
I feel I am walking on eggshells around him/her, afraid that if I say the wrong thing s/he will explode, fall apart, or walk out (DV)	2.500	6	.047	1.42
More than most patients, I feel like I've been pulled into things that I didn't realize until after the session was over (DV)	3.286	6	.017	1.71
<i>One of my parents has been diagnosed with a substance abuse disorder (IV)</i>				

Variables	T-Test	DF	P-Value*	DV Mean Difference
I am very hopeful about the gains s/he is making or will likely make in treatment (DV)	3.000	6	.024	2.00
I find it exciting to work with him/her (DV)	3.834	6	.009	1.16
I have to stop myself from saying or doing something aggressive or critical (DV)	4.500	6	.004	3.00
I watch the clock more often in sessions with him/her than with other clients (DV)	2.73	6	.034	.83
<i>Another immediate family member has been in treatment for substance use (IV)</i>				
I don't feel fully engaged in sessions with him/her (DV)	5.196	6	.002	1.50
I feel frustrated in sessions with him/her (DV)	2.611	6	.040	1.25
My mind often wanders to things other than what s/he is talking about (DV)	5.000	6	.002	1.25
<i>Another immediate family member has been diagnosed with</i>				

Variables	T-Test	DF	P-Value*	DV Mean Difference
<i>substance abuse disorder (IV)</i>				
I don't feel fully engaged in sessions with him/her (DV)	5.196	6	.002	.28
I feel frustrated in sessions with him/her (DV)	2.611	6	.040	.478
My mind often wanders to things other than what s/he is talking about (DV)	5.000	6	.002	.25
<i>An extended family member has been in treatment for substance abuse (IV)</i>				
I feel angry at him/her (DV)	3.250	6	.017	2.25
I have trouble relating to the feelings s/he expresses (DV)	4.243	6	.005	1.50
I feel pushed to set very firm limits with him/her (DV)	4.025	6	.007	2.25
<i>An extended family member has been diagnosed with substance abuse disorder (IV)</i>				
I feel pushed to set very firm limits with	2.862	6	.029	2.06

Variables	T-Test	DF	P-Value*	DV Mean Difference
him/her (DV)				
<i>A close friend has been in treatment for substance use (IV)</i> I call him/her between sessions more than my other patients (DV)	2.739	6	.034	.83
<i>A close friend has been diagnosed for substance abuse disorder IV)</i> I call him/her between sessions more than my other patients (DV)	2.739	6	.034	.83

*Significant (2-tailed)

The findings indicate a significant relationship between countertransference and chemical dependency counselors' substance abuse history, whether it be through personal use or through a family member or close friend's struggle with use. Each independent variable shows a relationship with at least one countertransference item and, therefore, indicates the importance of understanding countertransference and its effects on treatment outcome.

Discussion

The study explored if a significant relationship existed between substance abuse history and countertransference. For the sample in this study, past experiences of substance abuse were associated with countertransference in counseling sessions. Countertransference can negatively

affect the outcome of treatment. The relationship between the substance abuse counselor's substance use history and client treatment outcome establishes the importance of the current research study.

Interpretation of Findings

Participants who identified as experiencing personal use with substances showed a significant relationship with "feeling overwhelmed by a client's strong emotions" and the counselor's "having strong personal feelings stirred up in a session." These significant relationships show how past use of substances can impact personal feelings in present counseling situations (Nakajima & Muto, 2006). This finding shows that having a personal substance use history can be associated with strong feelings in counseling sessions.

The variables, "One of my parents has been in treatment for substance use" and "One of my parents has been diagnosed with a substance use disorder" showed different significant relationships among the countertransference variables. Those participants with parents who had been in treatment for substance use showed significant relationships with "feeling like he or she was walking on eggshells in sessions" and "felt like being pulled into things he or she did not realize until after sessions." Those participants with parents who had been diagnosed with a substance abuse disorder showed significant relationships with "feeling hopeful about gains the client is making," "feel excited to work with the client," "stopping self from being aggressive or critical in sessions," and "watching the clock less often in sessions than with other clients."

Participants who experienced the struggle of a parent with substance abuse showed a variety of countertransference items, which may connect with different emotions experienced while dealing with the participant's parent. It seems like experiencing a parent with substance abuse may cause feelings of anger, frustration, sadness, hope, and worry, and may contribute to the different

countertransference relationships found, such as walking on eggshells or feeling hopeful about gains the client is making.

Participants who identified having another immediate family member going through substance abuse treatment or being diagnosed with a substance use disorder showed a significant relationship with “not feeling engaged in sessions,” “feeling frustrated in sessions,” and “his or her mind wandering in sessions.” It appears that these significant relationships suggest that counselors who have experienced an immediate family member other than a parent struggling with substance abuse may find it difficult to connect with the client or staying present in the session, as well as having feelings of frustration with the client.

Participants who had experienced an extended family member being in treatment for substance use showed a significant relationship with “feeling angry with the client,” “having trouble relating to feelings the client expresses,” and “feeling pushed to set firm limits.”

Participants who experienced an extended family member diagnosed with a substance use disorder also showed a significant relationship with feeling pushed to set firm limits. It seems that the feeling to set firm limits may be associated with having to set limits and boundaries, or having a lack of limits, with a family member experiencing a struggle with substance use.

Participants who experienced a close friend being in treatment for substance abuse and being diagnosed with a substance use disorder showed a significant relationship with “calling the client in between sessions less often than with other clients.” It appears that this relationship may be associated with feeling worried and feeling the need to check on a close friend who has struggled with substance abuse.

Implications for Counseling

Due to the findings of a significant relationship between countertransference and substance abuse history among chemical dependency counselors, it is important to figure out what should be done to ensure the best client treatment outcomes. Chemical dependency counselors have the necessary task of becoming more aware of how their past experience with substance abuse may affect their current therapy. It is important for counselors to receive training about countertransference and how it may impact therapy in order to provide the most effective treatment.

Limitations of the Study

The current study was limited by the small sample size. In the convenience sample 36 individuals were given an opportunity to participate, and only 8 individuals submitted a completed survey. It is difficult to generalize the findings of the study to the whole population of chemical dependency counselors because of the small number of participants.

Another limitation of the current study is the length of the instrument used. The survey distributed to participants contained 91-questions. Due to busy schedules, a 91-question survey may have been very difficult for individuals to complete. Individuals may also not have had enough time to complete it in the two-week time frame given.

Another limitation is that the nature of the survey questions was very personal. Due to the questions being very personal and evoking thoughts into a participant's past, individuals may have not been mentally or emotionally prepared to complete the survey.

Future Research

Based on the finding of a significant relationship between countertransference and personal substance abuse history among chemical dependency counselors, it would be important to study a larger sample size of chemical dependency counselors to understand more about the

relationship. It would also be interesting and important for future research to focus on specific effects of countertransference on client treatment outcome. By focusing on how countertransference affects treatment outcome, counselors may become more self-aware of countertransference and be more effective in therapy.

It would be important to study substance-related countertransference in different counseling settings and with different populations, to include gender specific or other specific diagnoses, such as individuals dealing with an eating disorder or a mood disorder. Understanding more about substance-related countertransference is important to provide the best treatment possible for clients in substance abuse treatment as well as in other mental health treatment settings.

Conclusion

A significant relationship was found between countertransference and the chemical dependency counselor's personal substance abuse history. The importance of the study is to become more aware of the impact of past substance abuse on client treatment outcome in the chemical dependency field. Future research can help counselors to become more aware of the effects of countertransference on individuals receiving treatment.

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Appendix A

Dear Potential Participant,

My name is Megan Taylor and I am an intern here at the Restart program at Catholic Family Center. I will be conducting a research project and am asking for your participation in the study. The purpose of this research project is to examine the correlation of countertransference and experience with substance abuse among chemical dependency counselors. The areas that will be studied include the correlation between countertransference and chemical dependency counselors with personal recovery experience, experience with family members or close friends with substance abuse issues, or with no personal substance abuse experience at all. This research project is also being conducted in order for me to complete my master's thesis for the Department of Counselor Education at the College at Brockport, SUNY.

To participate in this study, you will need to fill out a 91 question survey. Participation is completely voluntary and you may leave the study at anytime. Confidentiality will be protected and the surveys will remain anonymous. All data will be destroyed at the completion of the research study.

I will be placing the surveys into each of your mailboxes and if you choose to participate there will be a locked box in the mailroom to place your completed surveys.

Please contact me with any questions or concerns.

Megan Taylor
Primary Researcher
(585)546-7220 ext.6229
mtaylor@cfcrochester.org

Appendix B

Cover letter

Dear Participant,

Megan Taylor, Mental Health Counselor Graduate intern, is conducting a study on the correlation of counter transference and experience with substance abuse among chemical dependency counselors which involves a survey of ninety questions that will take approximately twenty minutes to complete. The answers to this survey are important because a correlation will be researched between counter transference and personal history of chemical dependency counselors and will be used to inform mental health professionals about any correlation found. You are being asked to participate in this study and your answers to the attached survey signify your consent to participate. Please do not write your name on the survey. There will be no way in which you will be connected to this survey, and results will be reported in aggregate form only. You do not have to answer any questions that you do not want to answer, and you may stop participating in the survey at any time. It is hoped that approximately 75% of people will participate in the study. The results will be used to identify any correlation made between counter transference and chemical dependency counselor's personal experience with substance use.

Thank you for your participation in the survey. You may return the completed survey by placing in the drop box located in the second floor mail room. If you have any questions regarding this study you may contact:

Megan Taylor
Counselor Education
The College at Brockport, SUNY
(585)474-2965
mtay0524@brockport

Dr. Summer Reiner
Counselor Education
The College at Brockport, SUNY
(585)395-5497
sreiner@brockport.edu

Appendix C

STATEMENT OF INFORMED CONSENT

The purpose of this research project is to examine the correlation of counter transference and experience with substance abuse among chemical dependency counselors. The areas that will be studied include the correlation between counter transference and chemical dependency counselors with personal recovery experience, experience with family members or close friends with substance abuse issues or with no personal substance abuse experience at all. This research project is also being conducted in order for me to complete my master's thesis for the Department of Counselor Education at the College at Brockport, SUNY.

In order to participate in this study, your informed consent is required. You are being asked to make a decision whether or not to participate in the project. If you want to participate in the project, and agree with the statements below, then your completion of the survey signifies your consent. You may change your mind at any time and leave the study without penalty, even after the study has begun.

I understand that:

1. My participation is voluntary and I have the right to refuse to answer any questions.
2. My confidentiality is protected. My name will not be written on the survey. There will be no way to connect me to my written survey. If any publication results from this research, I would not be identified by name.
3. The anticipated risks of participation include potential for anxiety and feeling uncomfortable due to the personal nature of the survey questions.
4. My participation involves reading a written survey of 90 questions and answering those questions in writing.
5. Approximately 40 people will take part in this study. The results will be used for the completion of a master's thesis by the primary researcher.
6. Data will be kept in a locked drawer by the investigator. Data will be destroyed by shredding when the research has been accepted and approved.

I am 18 years of age or older. I have read and understand the above statements. All my questions about my participation in this study have been answered to my satisfaction. I agree to participate in the study realizing I may withdraw without penalty at any time during the survey process. Returning the survey indicates my consent to participate.

If you have any questions you may contact:

Primary Researcher
Megan Taylor
(585) 474-2965
mtay0524@brockport.edu

Faculty Advisor
Dr. Summer Reiner, Ph.D., LMHC, NCC
Counselor Education, (585) 395-2258
sreiner@brockport.edu

*Please note that if feelings of anxiety or feeling uncomfortable become present throughout the research study, you are encouraged to contact the following Community Licensed Mental Health Counselor to discuss any concerns:

Nancy E. Harris, LMHC, NCC
585-271-4770
46 Prince Street
Suite LL004
Rochester, NY 14607
counseling@nancyharris counseling.com

Appendix D

When completing this survey, please identify your most challenging client that you have worked with.

What is the reason you chose this particular client as most challenging?

1. The client's attitude towards treatment
 2. Behavioral issues with client
 3. Client's mental health diagnosis
 4. Demographic differences between you and the client
 5. Other: please explain
-

Where would you place this client on the readiness for change scale?

1. Pre-contemplation
2. Contemplation
3. Preparation
4. Action
5. Maintenance
6. Relapse

THERAPIST RESPONSE QUESTIONNAIRE

The statements below describe a number of ways clinicians feel about or react to their patients. Please rate the following items on the extent to which they are true of you in your work with your patient, where **1=not true at all, 3=somewhat true, and 5=very true**. We know it is hard to generalize across a treatment of many weeks or months, but try to describe the way you have felt with your patient over the course of the entire treatment. Do not worry if your responses appear inconsistent, since clinicians often have multiple responses to the same patient.

1. I am very hopeful about the gains s/he is making or will likely make in treatment. 1 2 3 4 5
2. At times I dislike him/her. 1 2 3 4 5
3. I find it exciting working with him/her. 1 2 3 4 5
4. I feel compassion for him/her. 1 2 3 4 5
5. I wish I had never taken him/her on as a patient. 1 2 3 4 5
6. I feel dismissed or devalued. 1 2 3 4 5
7. If s/he were not my patient, I could imagine being friends with him/her. 1 2 3 4 5
8. I feel annoyed in sessions with him/her. 1 2 3 4 5
9. I don't feel fully engaged in sessions with him/her. 1 2 3 4 5
10. I feel confused in sessions with him/her. 1 2 3 4 5
11. I don't trust what s/he's telling me. 1 2 3 4 5
12. I feel criticized by him/her. 1 2 3 4 5
13. I dread sessions with him/her. 1 2 3 4 5

14. I feel angry at people in his/her life. 1 2 3 4 5
15. I feel angry at him/her. 1 2 3 4 5
16. I feel bored in sessions with him/her. 1 2 3 4 5
17. I feel sexually attracted to him/her. 1 2 3 4 5
18. I feel depressed in sessions with him/her. 1 2 3 4 5
19. I look forward to sessions with him/her. 1 2 3 4 5
20. I feel envious of, or competitive with him/her. 1 2 3 4 5
21. I wish I could give him/her what others never could. 1 2 3 4 5
22. I feel frustrated in sessions with him/her. 1 2 3 4 5
23. S/he makes me feel good about myself. 1 2 3 4 5
24. I feel guilty about my feelings toward him/her. 1 2 3 4 5
25. My mind often wanders to things other than what s/he is talking about. 1 2 3 4 5
26. I feel overwhelmed by his/her strong emotions. 1 2 3 4 5
27. I get enraged at him/her. 1 2 3 4 5
28. I feel guilty when s/he is distressed or deteriorates, as if I must be somehow responsible. 1 2 3 4 5
29. S/he tends to stir up strong feelings in me. 1 2 3 4 5
30. I feel anxious working with him/her. 1 2 3 4 5
31. I feel I am failing to help him/her or I worry that I won't be able to help him/her. 1 2 3 4 5
32. His/her sexual feelings toward me make me anxious or uncomfortable. 1 2 3 4 5
33. I feel used or manipulated by him/her. 1 2 3 4 5
34. I feel I am "walking on eggshells" around him/her, afraid that if I say the wrong thing s/he will explode, fall apart, or walk out. 1 2 3 4 5
35. S/he frightens me. 1 2 3 4 5
36. I feel incompetent or inadequate working with him/her. 1 2 3 4 5
37. I find myself being controlling with him/her. 1 2 3 4 5
38. I feel interchangeable-that I could be anyone to him/her. 1 2 3 4 5
39. I have to stop myself from saying or doing something aggressive or critical. 1 2 3 4 5
40. I feel like I understand him/her. 1 2 3 4 5
41. I tell him/her I'm angry at him/her. 1 2 3 4 5
42. I feel like I want to protect him/her. 1 2 3 4 5
43. I regret things I have said to him/her. 1 2 3 4 5
44. I feel like I'm being mean or cruel to him/her. 1 2 3 4 5
45. I have trouble relating to the feelings s/he expresses. 1 2 3 4 5
46. I feel mistreated or abused by him/her. 1 2 3 4 5
47. I feel nurturant toward him/her. 1 2 3 4 5
48. I lose my temper with him/her. 1 2 3 4 5
49. I feel sad in sessions with him/her. 1 2 3 4 5
50. I tell him/her I love him/her. 1 2 3 4 5
51. I feel overwhelmed by his/her needs. 1 2 3 4 5
52. I feel hopeless working with him/her. 1 2 3 4 5
53. I feel pleased or satisfied after sessions with him/her. 1 2 3 4 5
54. I think s/he might do better with another therapist or in a different kind of therapy. 1 2 3 4 5
55. I feel pushed to set very firm limits with him/her. 1 2 3 4 5

56. I find myself being flirtatious with him/her. 1 2 3 4 5
57. I feel resentful working with him/her. 1 2 3 4 5
58. I think or fantasize about ending the treatment. 1 2 3 4 5
59. I feel like my hands have been tied or that I have been put in an impossible bind. 1 2 3 4 5
60. When checking my phone messages, I feel anxiety or dread that there will be one from him/her. 1 2 3 4 5
61. I feel sexual tension in the room. 1 2 3 4 5
62. I feel repulsed by him/her. 1 2 3 4 5
63. I feel unappreciated by him/her. 1 2 3 4 5
64. I have warm, almost parental feelings toward him/her. 1 2 3 4 5
65. I like him/her very much. 1 2 3 4 5
66. I worry about him/her after sessions more than other patients. 1 2 3 4 5
67. I end sessions overtime with him/her more than with my other patients. 1 2 3 4 5
68. I feel less successful helping him/her than other patients. 1 2 3 4 5
69. I do things for him/her, or go the extra mile for him/her, in ways that I don't do for other patients. 1 2 3 4 5
70. I return his/her phone calls less promptly than I do with my other patients. 1 2 3 4 5
71. I disclose my feelings with him/her more than with other patients. 1 2 3 4 5
72. I call him/her between sessions more than my other patients. 1 2 3 4 5
73. I find myself discussing him/her more with colleagues or supervisors than my other patients. 1 2 3 4 5
74. S/he is one of my favorite patients. 1 2 3 4 5
75. I watch the clock with him/her more than with my other patients. 1 2 3 4 5
76. I self-disclose more about my personal life with him/her than with my other patients. 1 2 3 4 5
77. More than with most patients, I feel like I've been pulled into things that I didn't realize until after the session was over. 1 2 3 4 5
78. I begin sessions late with him/her more than with my other patients. 1 2 3 4 5
79. I talk about him/her with my spouse or significant other more than my other patients. 1 2 3 4 5

Demographics

I've been in treatment for alcohol use. Yes No

I've been in treatment for drug use. Yes No

One of my parents has been in treatment for substance use. Yes No

One of my parents has been diagnosed with a substance use disorder. Yes No

Another immediate family member has been in treatment for substance use. Yes No

Another immediate family member has been diagnosed with a substance use disorder.

Yes No

An extended family has been in treatment for substance use. Yes No

An extended family has been diagnosed with a substance use disorder. Yes No

A close friend has been in treatment for substance use. Yes No

A close friend has been diagnosed with a substance use disorder. Yes No