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Countertransference Management and Effective Psychotherapy: Meta-Analytic Findings

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In this article, we review the history and definition of countertransference, as well as empirical research on countertransference, its management, and the relation of both with psychotherapy outcome. Three meta-analyses are presented, as well as studies that illustrate findings from the meta-analyses. The first meta-analysis indicated that countertransference reactions are related inversely and modestly to psychotherapy outcomes ($r = -.16$, $p = .02$, 95% CI [−.30, −.03], $d = -0.33$, $k = 14$ studies, $N = 973$). A second meta-analysis supported the notion that countertransference management factors attenuate countertransference reactions ($r = -.27$, $p = .001$, 95% CI [−.43, −.10], $d = -0.55$, $k = 13$ studies, $N =$ 1,065). The final meta-analysis revealed that successful countertransference management is related to better therapy outcomes ($r = .39$, $p < .001$, 95% CI [.17, .60], $d = 0.84$, $k = 9$ studies, $N = 392$ participants). In all meta-analyses, there was significant heterogeneity across studies. We conclude by summarizing the limitations of the research base and highlighting the therapeutic practices predicated on research.

Clinical Impact Statement
Question: What are the potential effects on outcome of psychotherapists' reactions that are based on their unresolved personal conflicts, and how can these reactions be managed effectively? ***Findings:*** Psychotherapists' unresolved personal conflicts can give rise to reactions that negatively affect the outcome of therapy, and successfully managing these reactions seems to be an important element in positive therapy outcomes. ***Meaning:*** Psychotherapists of all theoretical orientations need to attend to their personal conflicts and monitor their reactions to clients as a routine part of effective clinical practice. ***Next steps:*** Additional research would provide insight into various ways that psychotherapists can manage their countertransference reactions, and studies are especially needed across therapeutic modalities and with culturally diverse therapists and clients.

Keywords: countertransference, psychotherapy relationship, meta-analysis, psychotherapy outcome, therapist effects

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The concept of countertransference (CT) is nearly as old as psychotherapy itself. Like so many fundamental constructs in psychotherapy, the term was originated by Freud, shortly after the turn of the 20th century. Although Freud did not write extensively about CT, it was clear that he viewed it as problematic. Freud's view of CT as detrimental was likely a major influence in the field's neglect of the topic for many decades. It became something to be done away with rather than material worth examining. The

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good psychotherapist was, in fact, seen as capable of maintaining objectivity and keeping her or his personal conflicts out of the work. Beginning in the 1950s, conceptions of CT began to change. CT was increasingly viewed as an inevitable aspect of psychotherapy that could have positive or negative effects, depending on how the therapist dealt with it.

Around this same period, the first empirical studies on CT also emerged (Cutler, 1958; Fiedler, 1951). From then on, there has been a steady increase of clinical and theoretical writing on CT. As is so often the case, however, empirical efforts lagged behind theoretical work, although studies did appear occasionally. In recent years, however, significant changes have occurred in conceptualizations and research on CT. It has been theorized to be a key part of all psychotherapy relationships, and propositions have been offered about its operation across virtually all theoretical orientations and treatment formats (Brown, 2001; Ellis, 2001; Kaslow, 2001; Rudd & Joiner, 1997). In addition, laboratory analogue studies have sought to reduce this abstract construct to scientifically manageable proportions and have paved the way for clinically meaningful studies, both qualitative and quantitative (Hayes, 2004).

Definitions and Measures

Three conceptions of CT have been most prominent over the years: the *classical*, the *totalistic*, and the *complementary* (Epstein & Feiner, 1988). The classical definition, originated by Freud (1910/1957), posits that CT is the therapist's unconscious, conflict-based reaction to the patient's transference. Unresolved conflicts, typically originating in the therapist's early childhood, are triggered by the patient's transference, and are manifested by the therapist in one way or another. These manifestations may be affective, behavioral, somatic, or cognitive, and are seen as interfering with treatment.

The totalistic conception of CT originated in the 1950s (Heimann, 1960; Kernberg, 1965; Little, 1951). According to this conception, CT refers to and is synonymous with *all* of the therapist's reactions to the patient. All reactions are important, all should be studied and understood, and all are placed under the broad umbrella of CT. This definition legitimized CT and made it an object of the therapist's self-investigation and use. Accordingly, as the totalistic view gained ascendancy, CT was considered more and more as potentially beneficial to the work, if therapists studied their reactions and used them to advance their understanding of patients and patients' impact on others, including the therapist.

The view of CT as an inevitable reaction to the patient overlaps with the third conception: CT as a complement or counterpart to the patient's style of relating. This conception was developed in interpersonal, relational, and object relations theory (Anchin & Kiesler, 1982; Butler, Flasher, & Strupp, 1993; Levenson, 1995; Strupp & Binder, 1984). According to the complementary conception, the patient exhibits certain "pulls" on the therapist. For example, the patient who has an oppositional style will tend to generate oppositional thoughts and feelings in the therapist. The well-functioning therapist, however, does not act out *lex talionis* ("an eye for an eye, a tooth for a tooth"). The effective therapist, instead, restrains her or his "eye for an eye" impulse and seeks to understand what the patient is doing to stir up these reactions.

Each of these definitions of CT has limitations, but all three point to important elements of and factors related to CT. We favor an integrated definition of CT that includes learnings from all three conceptualizations (Gelso & Hayes, 1998, 2007). We thus define CT as *internal and external reactions in which unresolved conflicts of the therapist, usually but not always unconscious, are implicated*. All of the therapist's reactions are important and worthy of investigation, clinically and empirically, but the definition of CT must be narrower than the totalistic one if it is to be scientifically useful. Our conception of CT is similar to the classical in its focus on the therapist's unresolved conflicts as the source of CT, but it is different in that CT is seen as a potentially useful phenomenon if the therapist successfully understands his or her reactions and uses them to help understand the patient. It also differs from the classical conception in the sense that CT is not only a reaction to the patient's transference; it may be a reaction to many factors, both internal and external.

Thus, in seeing CT as both a hindrance and a potential aid to treatment, an integrative definition picks up on the two thematic constructs that have been intertwined, like a double helix (Epstein & Feiner, 1988), throughout the history of thought about CT. In addition, like the totalistic position, our integrative definition suggests that CT is inevitable. This is so because all therapists have unresolved conflicts and unconscious "soft spots" that are touched upon in working with other human beings. Furthermore, we suspect that in many or even most cases in which the therapist's intense reaction is a "natural" response to the patient, therapist's unresolved conflicts are implicated. Finally, like the complementary view, an integrative conception of CT, as we have said, does not solely focus on the therapist's reaction to the patient's transference. Rather, it incorporates the therapist's reaction to both transference and nontransference materials presented by the patient. The latter includes the patient's personality style, the actual content that the patient is presenting, and even the patient's physical appearance (Hayes, Nelson, & Fauth, 2015). Thus, despite the psychoanalytic origins of CT, and the classical view in particular, CT may—and probably should—be regarded as a pantheoretical construct. No theory "owns" CT, just as no therapist is immune to it.

Despite the definitional inconsistency, most empirical studies on CT use an operational definition that involves the therapist's unresolved conflicts as the origin and some characteristic of the patient as the trigger for CT reactions. These CT reactions have been operationalized in behavioral, cognitive, somatic, and affective terms (Fauth, 2006). Behaviorally, the most common indicators of CT have been therapists' avoidance of and withdrawal from personally threatening client material. For example, therapist avoidant reactions are those that inhibit, discourage, or divert session content, such as ignoring or mislabeling affect, changing topics, or allowing prolonged silences (Bandura, Lipsher, & Miller, 1960). Positively valenced behavioral manifestations have also been explored in the research literature, and examples include therapists' overinvolvement with their clients (Gelso, Fassinger, Gomez, & Latts, 1995) and therapists meeting their own needs by excessively nurturing their clients (Hayes et al., 1998, Hayes, Nelson, et al., 2015).

Cognitively, CT has been operationalized as therapists' perceptual distortions of clients and inaccurate recall of what clients discussed in session (Fauth & Hayes, 2006; Fiedler, 1951; Hayes

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& Gelso, 1993; McClure & Hodge, 1987). On a somatic level, a measure called the Body-Centered Countertransference Scale has been developed by a team of Irish researchers who have found that common visceral CT reactions include therapists' sleepiness, muscular tension, and headaches (Booth, Trimble, & Egan, 2010).

Affectively, the most common marker of CT is therapists' in-session anxiety, and it has commonly been measured by the State Anxiety Inventory (Hayes & Gelso, 1993, 2001). Research has explored additional affective CT manifestations, including pleasant feelings such as hope, happiness, and excitement, as well as unpleasant feelings, such as fear, worry, anger, sadness, and disappointment (Fauth & Hayes, 2006; Friedman & Gelso, 2000; Hayes et al., 1998; Hayes, Nelson, et al., 2015).

Psychotherapists' management of their CT reactions has been measured primarily with the Countertransference Factors Inventory (CFI; Van Wagoner, Gelso, Hayes, & Diemer, 1991) and several updated versions, all of which focus on five therapist qualities theorized to facilitate CT management: self-insight, conceptualizing ability, empathy, self-integration, and anxiety management. These factors do not reflect what a therapist actually does to manage CT, but they are more generally considered to be characteristics that are positively associated with CT management. On the CFI, therapists are rated on a Likert-type scale regarding the extent to which they possess the five qualities thought to facilitate CT management. Typically, these ratings are provided by clinical supervisors of therapist-trainees. A therapist self-report version of the CFI exists, but studies have not supported the validity of its scores.

In terms of the factors that comprise the instrument, therapist *self-insight* refers to the extent to which the therapist is aware of his or her own feelings, including CT feelings, and understands their basis. Therapist *self-integration* refers to the therapist's possession of an intact, basically healthy character structure. In the therapy interaction, such self-integration manifests itself as a recognition of interpersonal boundaries and an ability to differentiate self from other. *Anxiety management* refers to therapists allowing themselves to experience anxiety and also possessing the internal skill to control and understand anxiety so that it does not bleed over into their responses to patients. *Empathy*, or the ability to partially identify with and put one's self in the other's shoes, permits the therapist to focus on the patient's needs despite difficulties he or she may be experiencing with the work and the pulls to attend to his or her own needs. Also, an empathic ability may be part of a larger sensitivity to feelings, including one's own CT feelings, which in turn ought to prevent acting out of CT (Peabody & Gelso, 1982; Robbins & Jolkovski, 1987). Finally, *conceptualizing ability* reflects the therapist's ability to draw on theory in the work and grasp the patient's dynamics in terms of the therapeutic relationship.

Recently, a 22-item instrument called the Countertransference Management Scale was developed to directly assess the management of CT during therapy sessions (Pérez-Rojas et al., 2017). Factor analyses of 286 supervisors' ratings of supervisees yielded two subscales: Understanding Self and Client, and Self-Integration and Regulation. Evidence of convergent and criterion-related validity was provided through correlations with measures of theoretically relevant constructs, namely, therapist CT behavior, self-esteem, observing ego, empathic understanding, and tolerance of anxiety. This instrument appears to have promise as a direct measure of the extent to which therapists manage their CT reactions in sessions. It should be noted that the Countertransference Management Scale does subsume the five ingredients we have described under the broad umbrella of the two subscales. That is, self-insight, empathy, and conceptualizing ability appear to fit within the subscale labeled Understanding Self and Client, whereas self-integration and anxiety management reside within the Self-Integration and Regulation subscale.

Clinical Examples

A case example may illustrate the ways in which therapist reactions that are "normal" and understandable can be, and often are, tinged by the therapist's own conflicts. The case involved a therapist-trainee in her fourth practicum of a doctoral program, who was supervised by one of the authors, and who by every indication appeared to have extraordinary potential as a therapist (all participants in this section have been deidentified). In the early part of her work with a 20-year-old male patient, she experienced ongoing strong irritation and reacted to the patient in a controlled and muted manner. For his part, the patient was an angry, obsessional young man who had many borderline features. He negated the therapist's attempts to help him understand how he contributed to his ongoing problems with women, and he denied that therapy could have any impact. Also, he usually challenged or denied the therapist's observations about what he might be feeling.

Clearly, the therapist's emotional reactions were "natural," given the patient's negativity and hostility. Yet the therapist's reactions were also due to her own unresolved conflicts about not being good enough, about fearing that she could not take care of others sufficiently, and about her excessive fears of her supervisor's evaluation of her. As she came to understand these concerns, her irritation with the patient lessened, and she empathically grasped the frightening emotions that were underlying much of his negativity.

An example of more blatant CT comes from one of the authors' own experiences as a therapist. The therapist's father had struggled with alcoholism throughout his adult life, and he had recently died from cirrhosis caused by alcohol abuse. Before his father's death, the therapist had undergone several months of individual therapy to deal with his father's impending death, and the therapy was largely successful in resolving the therapist's competing feelings of anticipatory grief and anger at his father. Several weeks after his father's death, the therapist met for the first time with a male client who was approximately his father's age. The man was seeking therapy for help with marital difficulties, persistent procrastination problems, and stress related to finances. The therapist's own father had faced similar challenges in his later years, all of which the therapist viewed to be caused and exacerbated by his father's drinking. During the initial session, the therapist conducted a fairly standard intake assessment, asking questions about the client's symptoms and functioning in a variety of areas. When asked about his alcohol use, the client remarked that he drank on a daily basis, often alone, and could not recall the last day he had not had a drink. Toward the end of the session, the therapist indicated that he thought psychotherapy would be helpful in addressing the client's marital, financial, and procrastination problems. The therapist then told the client, in a rather cold and punitive tone, that he had a substance abuse problem, and that this would need to be addressed

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at the outset. The client neither agreed nor disagreed that he suffered from substance abuse, but he remarked that that was not why he sought treatment. The therapist grew irritated with the man and restated his position. They set an appointment for the following week, and the client was never seen nor heard from again.

In this instance, the therapist's lingering feelings of anger toward his own father regarding his alcoholism were taken out on the client, who, although similar to the therapist's father in many ways, was an undeserving recipient of the therapist's confrontational and unempathic stance. The fact that the client did not return for a second session is hardly surprising in retrospect, although it took the therapist a considerable amount of reflection to understand what had transpired and to decrease the likelihood that future clients would bear the brunt of unresolved conflicts he had with his father.

Results of Previous Reviews

The small but growing number of studies on CT has only recently made it possible for meta-analytic work to be conducted in this area. Meta-analyses have focused on summarizing findings in the following three domains: (a) the association between CT reactions and psychotherapy outcome (i.e., are CT reactions predictive of poorer outcomes?); (b) the relationship between CT reactions and CT management (i.e., are CT management factors associated with fewer CT reactions?); and (c) the association between CT management and psychotherapy outcome (i.e., does successful management of CT tend to predict better outcome?).

With regard to the relation between CT reactions and psychotherapy outcome, data from 10 studies indicated that the two were significantly and inversely related, as expected, though only slightly so ($r = -.16$; Hayes, Gelso, & Hummel, 2011). The implication here is that, although CT reactions are generally unfavorable, their effects account for only about 2%–3% of the variability in outcome. That being said, correlations between the frequency of CT reactions and measures of psychotherapy outcome do not take into account the potency of any one display of CT behavior, which can have damaging effects that are difficult to reverse. Furthermore, the fact that CT reactions can cause clients to drop out of therapy, as evidenced in the earlier clinical example in this chapter with the alcoholic client, would not be captured in studies that only measured outcome at or following termination. But as stated earlier, CT reactions—both internal and external—can be potential sources of insight into the client and one's relationship with the client (Hayes & Cruz, 2006). Therefore, it is perhaps not surprising that the magnitude of the correlation between CT reactions and outcome was not larger than .16.

On the whole, the evidence has accumulated to support a conclusion, though perhaps somewhat overstated, in a review of the CT literature offered more than 40 years ago:

> Perhaps the most clear-cut and important area of congruence between the clinical and quantitative literatures is the widely agreed-upon position that uncontrolled countertransference has an adverse effect on therapy outcome. Not only does it have a markedly detrimental influence on the therapist's technique and interventions, but it also interferes with the optimal understanding of the patient. (Singer & Luborsky, 1977, p. 449)

The more recent quantitative body of work suggests that therapists do not have to be perfect. They can have unwanted reactions to clients. Psychotherapy sessions, and patients, can and often do withstand these reactions, particularly when the working alliance is strong and when therapists subsequently understand, and perhaps even self-disclose, their reactions to clients (Ham, LeMasson, & Hayes, 2013; Myers & Hayes, 2006; Yeh & Hayes, 2011).

Previous meta-analyses on CT management provide partial insight into why this might be so. On the one hand, evidence from 11 studies suggests that CT management factors play little to no role in mitigating actual CT reactions ($r = -.14$, $p = .10$; Hayes et al., 2011). On the other hand, in seven studies, these same CT management factors were strongly associated with better psychotherapy outcomes ($r = .56$; Hayes et al., 2011). With these findings as a foundation, we now turn our attention to results from our updated meta-analytic work.

Meta-Analytic Review

Eligibility Criteria

We included all studies (published and unpublished) that reported data allowing the calculation of the correlations between CT reactions or CT management with psychotherapy outcome. Studies reporting data allowing the calculation of the correlation between CT reactions and CT management were also included.

Psychotherapy outcomes exist on a continuum from immediate to distal. Immediate outcomes pertain to the effects of treatment on a given phenomenon within the therapy hour, whereas distal outcomes address the effects of treatment on indices of client functioning or well-being at the end of treatment. In between immediate and distal outcomes reside a wide range of what might be called proximate outcomes—those that pertain to a series of sessions, as well as outcomes that are presumed to be the way station for more distal outcomes, for example, change in patient experiencing may be seen as proximal to change in the level of psychopathology, itself a more distal outcome. A striking feature of the empirical CT literature is the paucity of studies seeking to connect CT and its management to more distal outcomes. Most research on CT and its management focuses on immediate or proximate outcomes. Thus, each of the meta-analyses that are reported in this chapter examine whether the timing of the outcome (e.g., proximal vs. distal) moderated the findings.

Information Sources and Search Procedures

We searched the following databases: EBSCO, PsycINFO, and Google Scholar. We used the search terms *countertransference*, *countertransference management*, *therapy*, *outcome*, *relationship*, *reaction*, *working alliance*, *session quality*, and *management*. Titles and abstracts of potential studies were coded independently by two advanced undergraduate students under the guidance of the second author. Disagreements were discussed with the senior author. A total of 70 citations were retrieved. Following the application of the exclusion criteria, 36 studies were retained for analysis representing 2,890 participants.

Data Collection Process

Standardized spreadsheets were developed for coding both study-level and effect size-level data. Data were extracted inde-

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pendently by the second author and one of the undergraduate students who coded the titles and abstracts of studies. Disagreements were again discussed with the senior author. When sufficient data for computing standardized effect sizes were unavailable, study authors were contacted.

Along with information necessary for computing standardized effect sizes, the following data were extracted: (a) authors, (b) whether the study was published or unpublished, (c) year study was published (or conducted, in the case of unpublished studies), (d) journal in which the study was published (or if it was an unpublished dissertation), (e) predictor variables, (f) criterion variables, (g) sample size, (h) ethnicity of participants, (i) age of participants, (j) CT rater type, (k) r values, (l) whether hypothesis was confirmed, and (m) and one-tailed p values.

Summary Measures

The effect size measure that was calculated was Pearson's correlation coefficient (r). Standard methods were used to compute this effect size and its variance (Cooper, Hedges, & Valentine, 2009). The random effects meta-analyses were conducted using the R statistical software package and the "metafor" and "MAc" packages (Del Re & Hoyt, 2010; Viechtbauer, 2010).

Synthesis of Results

When multiple outcome variables were reported in a single study, data were aggregated first within studies using the MAc package and then between studies, based on the comparison of interest (and using the commonly employed assumption that outcomes within study are correlated at r = .50; Wampold et al., 1997). Summary statistics were computed as Pearson's r along with 95% confidence intervals (CIs). Heterogeneity was systematically assessed using the I^2 (measuring the proportion of between-study heterogeneity) and the Q statistic (assessing whether between-study heterogeneity exceeded that expected by chance alone). Random effects analyses were used.

Additional analyses tested the timing of outcome assessment as a moderator of the correlation between either CT reactions or CT management and outcome. Outcome timing was coded as proximal if outcome assessment reflected the outcome of a given session (e.g., session depth) and distal if outcome assessment reflected the outcome following the conclusion of treatment (e.g., at termination). Due to the small number of studies in each of the meta-analyses, other potential moderating variables were not examined.

Risk of Bias Across Studies

We assessed publication bias by visually inspecting funnel plots for asymmetry within the comparison of interest. In addition, primary models were reestimated using trim-and-fill methods that account for the asymmetric distribution of studies around an omnibus effect (Viechtbauer, 2010).

Meta-Analytic Results

CT reactions and psychotherapy outcome. A total of 14 studies reported the correlation between CT reactions and psychotherapy outcome (Table 1). The omnibus effect size was significant ($r = -.16$, 95% CI [−.30, −.03], $p = .020$, $d = -0.33$, $N =$ 973 participants), indicating that more frequent CT reactions were associated with poorer psychotherapy outcomes. The magnitude of this relationship is the same as reported in a previous meta-analysis examining CT reactions and outcome (Hayes et al., 2011), despite the more recent meta-analysis, including four additional studies and more than 200 additional participants. Thus, the size of the relationship is likely fairly reliable and suggests that the effects of CT reactions on psychotherapy outcomes, though small, can be detected. It is important to note that there was significant heterogeneity across studies, $I^2 = 75.49\%$, $Q(13) = 42.17$, $p < .001$. Evidence suggestive of publication bias was detected in the trim-and-fill analysis. After four studies were imputed to account for the asymmetric funnel plot, the correlation between CT and psychotherapy outcome was no longer significant ($r = -.07$, 95% CI [−.21, .07], $p = .31$, $d = -0.14$). A moderator test was conducted to determine whether the timing of outcome assessment (i.e., proximal vs. distal) impacted the magnitude of the correlation between CT and psychotherapy outcome. There was no evidence that this was the case, $Q(1) = 2.16$, $p = .142$.

CT management and CT reactions. A total of 13 studies reported the correlation between CT management and CT reactions (Table 2). The omnibus effect size was significant ($r = -.27$, 95% CI [−.43, −.10], $p = .001$, $d = -0.55$, $N = 1394$ participants), indicating better CT management was associated with fewer CT reactions. There was significant heterogeneity across studies, $I^2 = 91.20\%$, $Q(12) = 244.43$, $p < .001$, although there was no evidence of publication bias.

CT management and psychotherapy outcome. Nine studies reported the correlation between CT management and psychotherapy outcome (Table 3). The omnibus effect size was significant ($r = .39$, 95% CI [.17, .60], $p < .001$, $d = 0.84$, $N = 392$ participants), evidencing a medium to large-medium effect size. This finding indicates that better CT management was associated with larger gains in psychotherapy outcome. As with the previous meta-analyses, there was significant heterogeneity across studies, $I^2 = 88.55\%$, $Q(8) = 101.45$, $p < .001$. Evidence suggestive of publication bias was detected in the trim-and-fill analysis. After three studies were imputed to account for the asymmetric funnel plot, the correlation between CT management and psychotherapy outcome remained significant ($r = .51$, 95% CI [.30, .72], $p <$ .001, $d = 1.20$). A moderator test examined whether the association between CT management and outcome varied depending on when outcome was assessed. There was no evidence that this was the case, $Q(1) = 2.28$, $p = .131$.

Patient Contributions

Although CT is fundamentally a function of the therapist's own conflicts and vulnerabilities, there are some features of clients that serve to activate or provoke CT reactions. Thus, we believe that CT is best understood in terms of an interaction between the therapist's unresolved conflicts and aspects of the client that touch upon or stir up the therapist's conflicts. We refer to this interplay between therapist and client characteristics as the CT Interaction Hypothesis (Gelso & Hayes, 2007). Consistent with this hypothesis, the research does not support the view that there are common client characteristics that universally provoke CT (Hayes & Gelso, 1991, 1993; Robbins & Jolkovski, 1987; Yulis & Kieser, 1968). Instead, CT has a decidedly subjective nature to it, and this makes

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Table 1
Summary of Studies Relating Countertransference (CT) Reactions to Outcome

Authors	Year	Publication	Predictor	Criterion	N	Ethnicity (% White)	Age (mean years)	CT rater type	|r|	*r* variance	Hypothesis confirmed	*p* value (one tailed)
Bandura et al.	1960	*Journal of Consulting Psychology*	Approach-avoidance	Hostility	12 TH 17 CL	not reported	not reported	Observer	.53	.03	+	.04
Yeh & Hayes	2011	*Psychotherapy*	TH disclosure	CL rated TH quality & session quality	116 raters	88	21	Observer	.38	.01	+	.00
Williams & Fauth	2005	*Psychotherapy Research*	Self-awareness	Session evaluation	18 TH 18 CL	94 TH 75 CL	36 TH 22 CL	TH	.37	.04	+	.07
Hayes et al.	1997	*Psychotherapy Research*	CT behavior	CL improvement	20 TH 20 CL	80 TH 85 CL	31 TH 25 CL	TH & Sup	.33	.04	+	.08
Ligiero & Gelso	2002	*Psychotherapy: Theory, Research, Practice, Training*	Negative CT	Working alliance	50 TH	70	not reported	TH	.32	.02	+	.01
Bhatia & Gelso	2017	*Counselling Psychology Quarterly*	ICB	Session outcome	269 TH	92	not reported	TH	.18	.004	+	.01
Rossberg et al.	2010	*Psychiatry Research*	FWC-58	SCL-90R	11 TH 71 CL	not reported	32 CL 41 TH	TH	.29	.03	+	<.05
Westra et al.	2012	*Psychotherapy*	REACT	CRC	4 TH 30 CL	TH n/a 57 CL	TH n/a 40 CL	TH	.48	.02	+	.003
Cutler	1985	*Journal of Consulting Psychology*	Relevance to TH of CL problem	Task vs. ego responses	2 TH 5 CL	not reported	not reported	Observer	.24	.22		.30
Myers & Hayes	2006	*Psychotherapy: Theory, Research, Practice, Training*	CT	Session quality	224 raters	89	20	Observer	.04	.004		.28
Kim	2013	*Dissertation Abstracts International*	Race of CL & TH, CT, racial bias	GAF, prognosis	56 TH 56 CL	70	32	TH	.11	.02		.01
Rosenberger & Hayes	2002	*Journal of Counseling Psychology*	Approach-avoidance	BSI, WAI, Session quality	1 TH 1 CL	100 TH 100 CL	34 TH 21 CL	Observer	.06	.99		.86
Mohr et al.	2005	*Journal of Counseling Psychology*	CT behavior	Session quality	27 TH 88 CL	not reported	not reported	Sup	.04	.01		.37
Hayes, Yeh et al.	2007	*Journal of Clinical Psychology*	Unresolved grief	TH empathy, WAI-S, SEQ	69 TH 69 CL	89 TH 93 CL	54 TH 47 CL	TH	.03	.01		.40

Note. TH = therapists; CL = clients; SUP = supervisors; ICB = Inventory of Countertransference Behavior; FWC-58 = Feeling Word Checklist-58; SCL-90R = Symptom Checklist-90-Revised; REACT = Ratings of Emotional Attitudes to Clients by Treaters; CRC = Client Resistance Code; n/a = not applicable; GAF = Global Assessment of Functioning; BSI = Brief Symptom Inventory; WAI = Working Alliance Inventory; WAI-S = Working Alliance Inventory-Short; SEQ = Session Evaluation Questionnaire.

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Table 2
Summary of Studies Relating Countertransference (CT) Reactions to Countertransference Management

Authors	Year	Publication	Predictor	Criterion	*N*	Ethnicity (% White)	Age (mean years)	CT rater type	|*r*|	*r* variance	Hypothesis confirmed	*p* value (one tailed)
Friedman & Gelso	2000	*Journal of Clinical Psychology*	CFI-R	Inventory of CT behavior	149 Sup	91	49	Sup	.59	.003	+	.00
Hofsess & Tracey	2010	*Journal of Counseling Psychology*	CFI	Experiences with CT	35 TH 12 Sup	54 TH 67 Sup	28 TH 38 Sup	TH	.57	.01	+	.00
Latts & Gelso	1995	*Psychotherapy: Theory, Research, Practice, Training*	Self-awareness; Use of theory	Avoidance	47 TH	25	29	Observer	.45	.01	+	.00
Williams & Fauth	2005	*Psychotherapy Research*	Self-awareness	Negative stress	18 TH 18 CL	94 TH 75 CL	36 TH 22 CL	TH	.43	.04	+	.00
Williams et al.	2003	*Psychotherapy: Theory, Research, Practice, Training*	Self-awareness	Private self-consciousness	301 TH	92	51	TH	.29	.003	+	.04
Fatter & Hayes	2013	*Psychotherapy Research*	Meditation experience, mindfulness, and self-differentiation	CT management	78 Sup 100 TH	81 TH 78 Sup	not reported	Sup	.28	.01	+	.05
Peabody & Gelso	1982	*Journal of Counseling Psychology*	Therapist empathy	CT behavior	20 TH 20 CL	not reported	not reported	Observer	.24	.05		.15
Hayes, Riker, Ingram	1997	*Psychotherapy Research*	CFI-R	CT index; avoidance	20 TH 20 CL	80 TH 85 CL	31 TH 25 CL	TH, Sup, & Observer	.18	.05		.22
Kholocci	2007	*Dissertation Abstracts International*	Mindfulness	CT Questionnaire	203 TH	90 TH 80 CL	42 TH 40 CL	TH	.15	.005		.19
Forester	2001	*Dissertation Abstracts International*	Body awareness	Vicarious traumatization	96 TH	60	39	TH	.10	.01		.17
Robbins & Jolkovski	1987	*Journal of Counseling Psychology*	Self-awareness; Use of theory	Withdrawal of involvement	58 TH	91	29	Observer	.04	.02		.38
Gelso et al.	1995	*Journal of Counseling Psychology*	CFI	Cognitive, affective, behavioral CT	68 TH	56	not reported	TH & Observer	.04	.01		.40
Pérez-Rojas et al.	2017	*Psychotherapy*	CT Management Scale	CT behavior	286 Sup	87	56	Sup	.66	.002	+	.001

Note. CFI-R = Countertransference Factors Inventory-Revised; CFI = Countertransference Factors Inventory; TH = therapists; CL = clients; SUP = supervisors.

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Table 3
Summary of Studies Relating Countertransference (CT) Management to Outcome

Authors	Year	Publication	Predictor	Criterion	*N*	Ethnicity (% White)	Age (mean years)	CT MGMT rater type	Hypothesis confirmed	$\lvert r \rvert$	*r* variance	*p* value (one tailed)
Latts	1996	*Dissertation Abstracts International*	CFI	TH effectiveness	77 TH 77 Sup	69 TH 74 Sup	29 TH 41 Sup	Sup	+	.89	.001	.00
Van Wagoner et al.	1991	*Psychotherapy: Theory, Research, Practice, Training*	CFI	TH excellence	122 TH	not reported	48	Observer	+	.55	.004	.00
Peabody & Gelso	1982	*Journal of Counseling Psychology*	Openness to CT feelings	TH empathy	20 TH–CL pairs	not reported	not reported	Observer	+	.42	.04	.03
Ryan et al.	2012	*Psychotherapy Research*	KIMS	SCL-90, IIP	26 TH 26 CL	35 CL TH not reported	not reported	TH	+	.18	.04	.01
Gelso et al.	2002	*Journal of Clinical Psychology*	CFI	CL outcome	32 TH 15 Sup 63 CL	not reported	29 TH Sup not reported CL not reported	Sup	+	.39	.01	.01
Williams & Fauth	2005	*Psychotherapy Research*	Self-awareness	Session evaluation	18 TH 18 CL	94 TH 75 CL	36 TH 22 CL	TH		.18	.06	.25
Fauth & Williams	2005	*Journal of Counseling Psychology*	Self-awareness	TH helpfulness	17 TH 17 CL	65 TH 82 CL	24 TH 22 CL	TH		.17	.06	.00
Rosenberger & Hayes	2002	*Journal of Counseling Psychology*	CFI-R	BSI, session quality, alliance	1 TH 1 CL	100 TH 100 CL	34 TH 21 CL	Observer	+	.38	.73	.03
Leidenfrost	2015	*Dissertation Abstracts International*	CFI-R	CL outcome (Schwartz Outcome Scale)	9 Sup TH 50	89 Sup 90 TH	not reported	Sup		.002	.02	>.05

Note. MGMT = management; CFI = Countertransference Factors Inventory; TH = therapists; Sup = supervisors; CL = clients; KIMS = Kentucky Inventory of Mindfulness Skills; SCL-90 = Symptom Checklist-90; IIP = Inventory of Interpersonal Problems; CFI-R = Countertransference Factors Inventory-Revised; BSI = Brief Symptom Inventory.

sense given therapists' idiosyncratic histories, conflicts, and vulnerabilities (Fauth, 2006; Kiesler, 2001). The perfectionistic, self-critical client may evoke CT reactions in the therapist who struggles with her own perfectionism and may not prove at all difficult for the therapist who is not a perfectionist. As a result, it is incumbent upon therapists to understand themselves, their own inner workings, and to know what types of clients will likely provoke their CT reactions.

Limitations of the Research

Although the empirical literature on CT management is promising, there is still much left to be explored in this realm. Perhaps the most serious limitation to the research at the present time is the dearth of studies that link CT and its management to distal treatment outcomes. As a result, the link between CT behavior and treatment outcome is a tenuous one. Effects of CT and its management on outcome may be inferred from the data. However, there is precious little *direct* empirical support for such conclusions. In other words, if CT contributes to avoiding a patient's feelings, recalling the content of sessions inaccurately, and becoming overinvolved in the patient's problems, then it seems likely that its effects on the treatment outcome are adverse. Further, if CT behavior is negatively related to sound working alliances and to supervisors' evaluations of treatment effectiveness, then it also seems safe to suggest that uncontrolled CT is harmful to psychotherapy. At the same time, we could locate only one study (Hayes, Riker, & Ingram, 1997) seeking to connect CT behavior to treatment outcomes beyond immediate or proximate outcomes, and the results of that study only partially support the link of CT to outcome.

Clearly, research is needed on how CT and its management are related to the end of treatment outcomes, not only in terms of main effects (relating aspects of both to outcome) but also in terms of the conditions under which CT affects outcome. For example, does the effect depend upon patient qualities (e.g., personality, culture, severity, and type of disturbance), therapist qualities (competence, experience, and self-awareness), and the qualities of CT itself (positive vs. negative, CT feelings vs. CT behavior, and mild vs. extreme CT)? Also of interest are the ways in which CT may directly versus indirectly influence outcome. For example, it may be that the degree of CT in a given therapy directly affects the working alliance, which in turn directly influences outcome. In this instance, CT may not directly relate to outcome, but instead affects outcome *through* its influence on alliance. Path analytic models might be fruitfully applied to CT research to examine such direct and indirect effects.

Because of the relatively small number of studies in each of the meta-analyses, the magnitudes of the effects detected are likely to change as research accumulates in this area. That being said, it is unlikely that the directions of the relations will change. The data support the theoretical suppositions that CT reactions negatively affect therapy outcomes, that sound CT management by the therapist mitigates CT, and that such successful management also enhances therapy outcomes.

Another limitation of the current research literature is that all of the studies that have been conducted to date focus on individual therapy. The empirical literature is silent on CT and its management in group, couple, and family therapy, although we suspect that these would be fertile areas for future research endeavors.

Diversity Considerations

The CT literature has addressed culture to only a small degree, most notably in the areas of sexual orientation and gender. In a pair of studies examining CT in response to clients of various sexual orientations, therapist-trainees' verbal responses to clients exhibiting relational and sexual problems, contrary to expectation, did not reflect greater CT when these clients were gay (Hayes & Gelso, 1993) or lesbian (Gelso et al., 1995) than when they were heterosexual. However, these trainees' levels of homophobia predicted avoidance of client material in their responses to gay and lesbian, but not heterosexual, clients.

In the aforementioned Gelso et al. (1995) study, there was also some indication that therapist gender interacted with sexual orientation. When responding to a lesbian client, female therapists exhibited greater CT than males, whereas when responding to a heterosexual client, male and female therapists did not differ in their displays of CT. Interestingly, the measure of CT that differentiated male and female therapists when interacting with lesbian and heterosexual clients was the accuracy of recall of sexual words that the client expressed. Female therapists had a poorer recall of the number of sexual words than did male therapists when responding to lesbian clients (but not heterosexual clients). These findings are part of a small but important body of literature on the complex ways in which gender relates to CT (Gelso & Hayes, 2007; Latts & Gelso, 1995).

As of the writing of this article, there is an obvious need for research on CT reactions that may stem from other aspects of the client's or the therapist's culture, such as religion, disability status, age, ethnicity, and race. As regards the latter, some recent research has found differential therapist effectiveness as a function of client race and ethnicity (Hayes, Nelson, et al., 2015; Hayes, Owen, & Bieschke, 2015; Hayes, Owen, & Nissen-Lie, 2017). We suspect that culture-related CT reactions are implicated in these therapist effects (Gelso & Mohr, 2001).

Therapeutic Practices

The meta-analytic evidence points to the likely conclusions that the acting out of CT is typically harmful, though not necessarily irreparably so, and that CT management typically proves helpful to patient outcomes. From these rather general conclusions, a number of specific clinical practices can be recommended.

- The effective therapist must work at not acting out internal CT reactions.
- The five CT management factors appear to be useful for understanding and controlling CT manifestations. Self-insight seems particularly important to cultivate, and continually so. A therapist must take seriously Socrates' advice to "know thyself" or else risk having unknown aspects of the self undermine one's work with a client. "We should be the constant objects of our own observation, looking for any intense feelings about patients, and being vigilant about what the next instant will be in which our unconscious may betray us" (Robiertello & Schonewolf, 1987, p. 290).

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- Practice the demanding task of honest, impartial, and persistent self-observation. Self-awareness fosters an understanding of others, and our own blind spots can interfere with our empathy for and insight into others.
- Therapists should work on their own psychological health, including healthy boundaries with patients. Self-integration, along with self-insight, allows the therapist to pay attention to how the client is affecting the therapist and why. Such understanding is the first step in the process of arriving at ways in which CT may be useful to the work. When the therapist seeks to understand internal conflicts that are being stirred by the patient's material, the therapist also considers how this process may relate to the patient's life outside the consulting room—to both the patient's earlier life and current life. Then the therapist may be in a good position to devise responses that will be helpful to the patient. The specific nature of such responses will depend importantly upon the therapist's theoretical orientation, for example, psychoanalytic therapists may offer more accurate and well-timed interpretations, whereas humanistic therapists will use their understanding to empathize more deeply, and cognitive–behavioral therapists may offer more useful suggestions. But the essential point is that the therapist's awareness of underlying CT conflicts forms a basis for the effectiveness of her or his responses to clients.
- Self-integration underscores the importance of the therapist resolving major conflicts, which in turn points to the potential value of personal therapy for the psychotherapist (Geller, Norcross, & Orlinsky, 2005). Personal therapy for the therapist seems especially important when dealing with chronic CT problems. Although the evidence supports the view that CT occurs in a high percentage of sessions, it seems obvious that chronic CT problems need to be dealt with by the therapist, and that personal treatment is a likely vehicle for such resolution.
- Clinical supervision, for experienced therapists as well as trainees, is another key factor in understanding and managing CT and in using it to benefit clients. Of course, it is helpful if supervisors themselves actively conduct psychotherapy to remain sensitive to the realities and challenges posed by CT.
- When dealing with CT that has already been acted out, the therapist needs to understand that indeed he or she was acting out personal conflicts, and some research points to the value of the therapist's admission that a mistake was made and that it was the therapist's conflicts that were the primary source (Hill, Nutt-Williams, Heaton, Thompson, & Rhodes, 1996; Myers & Hayes, 2006). Therapists need not go into detail about their problems, for doing so more often than not serves therapists' needs more than the patient's. Yet the admission does appear to benefit the work—if a strong working alliance is in place (Yeh & Hayes, 2011)–and to diminish potential impasses.
- Therapists are likely to benefit from engaging in a regular and sustained meditation practice. Meditation promotes emotion regulation (Davis & Hayes, 2011) and has been found in both qualitative and quantitative research to benefit CT management (Baehr, 2005; Fatter & Hayes, 2013).
- Finally, therapists should practice self-care, including getting enough sleep, limiting the number of patients they see, spending time with friends, eating healthily, exercising regularly, and focusing on the rewards of conducting therapy. These behaviors are associated with practitioner resilience and ultimately better psychotherapy outcomes (Norcross & VandenBos, 2018).

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