Wounded Versus Non-Wounded Healers and Substance Abuse Treatment: Countertransference Considerations

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INTRODUCTION

Alcoholism and drug addiction place an enormous burden on American society, costing our nation over $600 billion annually in increased health care costs, crime, and lost productivity.[1] Effective and successful service delivery reduces associated health and social costs by far more than the cost of treatment itself. Unfortunately, however, relapse rates for addiction are as high as 40-60 percent and treatment completion rates are, on average, a mere 47 percent.[2]

There is scant attention in the literature about a major factor that often determines whether a positive therapeutic alliance will develop and whether substance use treatment will be effective and successful: the affective, cognitive, and behavioral countertransference of the practitioner.

In the field of substance use, where as many as 60-70 percent of practitioners are wounded healers and where agencies recruit wounded healers and clients often request wounded healer therapists, little attention has been paid to the unique countertransference manifestations of these individuals.[3]

To address this gap, this research study examined how countertransference in the client-practitioner relationship during substance use treatment is affected by the practitioner's own history of substance use.

DEFINITIONS

Wounded Healer: A practitioner who meets the criteria for substance use disorder in sustained remission for a period of 12 months of longer, as outlined in the DSM 5 (DSM 5, p.483-589).

Countertransference (CT): The practitioner's internal or external reactions that are shaped by the practitioner's past or present emotional conflicts and vulnerabilities and that are triggered by some subtle or overt behavior on the part of the client or by an aspect of the therapeutic situation or frame.[4]

CT Manifestations: Practitioner's behaviors (behavioral manifestation), thoughts (cognitive manifestation), and/or feelings (affective manifestation) that result from the triggering of the practitioner's unresolved issues and/or conflicts.[5]

METHODS

- This research was conducted as a qualitative study. Grounded theory was used to analyze the data and 20 wounded healer and 20 non-wounded healer participant practitioners were interviewed. All participants were providers of direct clinical services in abstinence-based outpatient substance use treatment agencies in the Tri-state area.
- A purposeful sample method was used to inform an understanding of the study's research problem and central phenomenon.[6] To minimize selection bias in the sample, every third individual out of a list of 500 practitioners was picked as a possible candidate and emailed. The first 40 who responded (20 wounded and 20 non-wounded healers) were used.
- Data was collected through in-person, semi-structured interviewers and run through Atlas TI for data analysis to identify word patterns in transcribed data until saturation occurred.

RESULTS

KEY

WH (Wounded Healer) NWH (Non-Wounded Healer)

COUNTERTRANSFERENCE MANIFESTATIONS

Affective Manifestation in Wounded Versus Non-Wounded Healers

AFFECTIVE MANIFESTATION	WH	NWH
Frustration	13	8
Anger	12	5
Decrease Empathy	13	9
Increase Empathy	9	16
Hurt/Sad	1	13
Over-Protective	11	10

Behavioral Manifestations in Wounded Versus Non-Wounded Healers

BEHAVIORAL MANIFESTATION	WH	NWH
Body Language	9	8
Giving Client Less Time	12	9
Giving Client More Time	5	16
Use of Non-Clinical Language	5	3
Confrontational	10	4

Cognitive Manifestations in Wounded Versus Non-Wounded Healers

COGNITIVE MANIFESTATION	WH	NWH
Prematurely Diagnosing	7	5
Push Own Clinical Agenda	12	4
Prolong Treatment	4	12
Enable	3	15
Refer Out Prematurely	11	5
Do Excess Work for Client	4	13

COUNTERTRANSFERENCE TRIGGERS

Countertransference Triggers in Wounded Versus Non-Wounded Healers

COUNTERTRANSFERENCE TRIGGER	WH	NWH
Resemble Family	7	14
Resemble Self	10	4
Personality D/O	9	10
Therapy Content	2	4
Client Missing Session	0	4
Relapse	10	12
+ Toxicology Denial	10	12

IDENTIFIABLE OUTCOMES ASSOCIATED WITH DIFFERENTIAL COUNTERTRANSFERENCE MANIFESTATIONS

Outcomes Associated with Negative Affective Countertransference

OUTCOME	WH	NWH
Confront	13	15
Push Own Agenda	11	9
Surface Level Work	13	14
Overuse of Self-Disclosure	7	0
Low Retention	16	16
Inappropriate Referral Out	13	16
Ineffective Treatment	14	16
Negative Therapy Alliance	14	20

Outcomes Associated with Positive Affective Countertransference

OUTCOME	WH	NWH
Miss a Relapse	0	13
Use MI Techniques	17	12
High Retention	15	17
Deep Therapeutic Work	14	16
Positive Therapy Alliance	15	19

Outcomes Associated with 'Feeling Over-Protective' of a Client

OUTCOME	WH	NWH
Over-Involved with Client	13	15
Keep in Treatment too long	7	10
Client not Learning Skills	12	12
Missed Relapses	2	10

Outcomes Associated with Identification with a Client

OUTCOME	WH	NWH
Push Own Clinical Agenda	13	7

DISCUSSION

This study uncovered several important insights on countertransference issues in wounded versus non-wounded healers during substance abuse treatment:

- Across each study group, practitioners agreed that positive affective countertransference can lead to deeper therapeutic work, longer stays in treatment, increased use of motivational interviewing versus confrontation, and ultimately, a positive alliance which is associated with positive outcomes.
- Non-wounded healers however, recognized that positive affective manifestations can cause a practitioner to become over-involved or over-protective of a client which can lead to negative outcomes such as missed relapses, enabling and not giving clients space to master skills.
- Across study groups, practitioners agreed that negative affective countertransference can lead to surface-level work, shorter stays in treatment, over-use of confrontation, and, ultimately, a negative alliance and poor treatment outcome.
- Wounded healers experienced higher levels of negative affective countertransference such as frustration, anger, decreased empathy and emotional disengagement.

CONCLUSION

To conclude, studying the varied countertransference experiences of wounded and non-wounded healer practitioners showed that one's status as a wounded healer impacts countertransference and thus clinical work. Wounded healers may need to be more vigilant than their non-wounded healer counterparts in the management of potentially harmful treatment effects. While appropriate recognition, analysis, and application of countertransference issues can be used to facilitate and enhance therapy processes and outcomes, a lack of awareness can negatively impact the therapeutic alliance, process and outcome.

REFERENCES

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