

2010

Countertransference Behavior and Alliance Quality as a Function of Therapist Self-Insight

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**COUNTERTRANSFERENCE BEHAVIOR AND ALLIANCE QUALITY AS A
FUNCTION OF THERAPIST SELF-INSIGHT**

A Thesis Presented

By

MAMTA BANU DADLANI

Submitted to the Graduate School of the
University of Massachusetts at Amherst in partial fulfillment
of the requirements for the degree of

MASTER OF SCIENCE

May 2010

Clinical Psychology

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DEDICATION

To my patients, who have forced me to look deep within myself
and
to my family, who taught me how to do so.

ABSTRACT

**COUNTERTRANSFERENCE BEHAVIOR AND ALLIANCE QUALITY AS A
FUNCTION OF THERAPIST SELF-INSIGHT**

MAY 2010

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Directed by: Professor Michael Constantino

The current study investigated preliminarily therapists' countertransference (CT) behavior and alliance quality as a function of therapist self-insight, a central CT management factor. Eight therapist-trainees were rated by a clinical supervisor on their degree of self-insight and then assigned to a high or low self-insight group. The groups were compared on therapist CT behavior, from both therapist and supervisor perspectives, and on patient-perceived alliance quality. Effect size estimates suggested that high self-insight therapists displayed more CT behaviors than low self-insight therapists (with small to medium effects), and that patients of high self-insight therapists reported higher alliance scores (with a medium effect). These findings, albeit preliminary and requiring replication with a larger sample, support the notion that self-insight plays a role in therapists' use of CT reactions in the service of effective therapeutic interventions.

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CHAPTER I

TOWARDS AN UNDERSTANDING OF COUNTERTRANSFERENCE

Definitions of Countertransference

Psychotherapists have long recognized the power of psychosocial treatments to arouse personal reactions among its interactants. In fact, the crux of Freud's (1910) classical psychoanalysis was the interpretation of a patient's *transference*, or displaced thoughts, feelings, conflicts, and/or needs onto his or her analyst as if the analyst were an important other from the patient's life. Recognizing the bidirectional nature of therapy reactions, Freud also discussed *countertransference* (CT), a therapist's unconscious and defensive reactions to a patient's transference. Freud posited that CT resulted from therapists' failure to resolve their own unconscious conflicts, and he argued that CT hindered therapists' ability to fully understand their patients. Thus, CT was initially conceptualized as a detrimental therapy process to be avoided.

Since Freud's (1910) introduction, CT has been the subject of much controversy and debate, and variations on CT definitions have emerged (for a comprehensive review see Gelso & Hayes, 2007). For example, some object relationists (e.g., Kernberg, 1965; Winnicott, 1949) working with severely disturbed patients began to accept the inevitability of their personal responses to patients and espoused using *all* affective reactions as an important source of clinical information about the patient's internal world. This *totalistic* definition posits that any therapist reactions across cognitive, affective, behavioral, latent, and/or manifest domains are evidence of CT.

Later, interpersonal theorists (e.g., Kiesler, 2001; Racker, 1957; Teyber, 1997)

also explored the utility of therapists' emotional responses to patient material. In contrast to the totalistic perspective, however, interpersonal theorists identified predictable and reliable patterns of therapist responses to patients' maladaptive relational styles. This *complementary* perspective posits that predictable therapist responses to patients' interpersonal "pulls" or "bids" are evidence of CT.

Although the classical, totalistic, and complementary CT perspectives have heuristic value, the clinical utility of CT has been limited by each definition's focus on unique and independent elements of the construct. Responding to this shortcoming, Gelso and Hayes (2007) articulated an *integrative* definition that conceptualizes CT as therapists' internal or external responses to their patients that are prompted by real events in either therapy or the therapist's life, and are reflective of or influenced by therapists' own emotional conflicts and vulnerabilities. Truly therapist-based, the integrative definition captures both momentary, reality-based interpersonal process (consistent with the totalistic and complementary perspectives), as well as intrapsychic contributors to this process (consistent with the totalistic and classical perspectives).

Despite definitional disparities and CT's conceptual complexity, a seeming consensus has emerged that CT feelings are unavoidable elements of therapy and, contrary to Freud's (1910) initial supposition, *do not necessarily harm* the therapeutic process (Gelso & Hayes, 2007; Hayes et al., 1998; Kiesler, 2001). In fact, from this contemporary perspective, CT experiences may be examined and used to understand more fully the therapy dynamics and to enhance the change process. However, if a therapist does not acknowledge CT feelings, he or she may neglect the patient's needs in the service of playing out his or her own conflicts, resulting in countertherapeutic

behavior. Thus, the nature of behavioral CT manifestations can have a powerful influence on the therapy process.

Types of CT Behaviors

One frequent CT behavior is a therapist's avoidance of or withdrawal from the patient and patient material. In one of the earliest CT investigations, Cutler (1958) examined therapist response quality to patient material identified as conflictual for the therapist. Audio recordings of therapists' verbal utterances were coded in terms of the therapists' task- and ego-orientation. Task-orientation, Cutler suggested, aims to facilitate the patient's focus on therapeutically relevant information, while ego-oriented responses depart from this focus to meet the therapist's own needs. Cutler found that when confronted with conflictual material, therapists tended to over- and under-emphasize material related to their own needs and conflicts, and offered ego-oriented, avoidant responses rather than task-oriented responses. Subsequently, avoidance and withdrawal have received considerable support in the literature as central behavioral CT responses (Hayes et al. 1998; Hayes & Gelso, 1991; Lecours, Bouchard, & Normandin, 1995; Mohr, Gelso, & Hill, 2005). Furthermore, avoidance and withdrawal have been examined with regard to patient characteristics such as sexual orientation (Gelso, Fassinger, Gomez, & Latts, 1995; Hayes & Gelso, 1993), style of presentation (Peabody & Gelso, 1982; Yulis & Kiesler, 1968), and presenting issue (Latts & Gelso, 1995), as well as to therapist characteristics such as expression of hostility (Bandura, Lipsher, & Miller, 1960) and homophobia (Gelso et al., 1995; Hayes & Gelso, 1991).

Although the CT literature has emphasized avoidance and withdrawal, therapist approach responses have more recently come under conceptual and empirical scrutiny as

a CT behavior. As Bandura et al. (1960) have defined, therapist approach responses are “designed to elicit from the patient further expressions of...feelings, attitudes, and behaviors” (p. 2) and include approval, instigation, exploration, reflection, and labeling. When used appropriately, such approach behaviors reflect adaptive treatment activity (Campbell & Browning, 1975; Caracena, 1965; Hayes & Gelso, 1993; Schuldt, 1966; Varble, 1968). Thus, therapist approach behaviors appear to facilitate treatment processes, these same behaviors may interfere with treatment when used inappropriately. Cutler (1958) first introduced the idea of maladaptive approach in his description of CT as a case of perception influenced by need; he suggested that therapist ego-oriented behavior also occurred when therapists overemphasized patient material that actually related to their own conflicts. Subsequent theoretical, clinical, and empirical work has also supported the notion of maladaptive approach (Hayes et al., 1998; Langs, 1977; Latts & Gelso, 1995; McClure & Hodge, 1987). For example, Hayes et al. conducted a consensual qualitative interview study of therapists to assist in developing an empirically-based and clinically-informed theory of CT. The authors found that therapists often responded to their own anxieties with a desire to “decrease the distance” (p. 475) between them and their patients. Similarly, Purcell (2004) identified approach-based CT in his theoretical description of CT sources in psychoanalytic work. He argued that approach-based CT blinds the therapist to the patient’s resistances and enables therapists to focus their attention solely on the mature and developing aspects of the patient’s personality – a therapy process that undermines substantive change.

Although the theoretical and clinical literatures implicate maladaptive approach as a CT behavior, this construct has undergone only limited empirical examination. Gelso et

al. (1995) assessed the cognitive, affective, and behavioral CT responses of 68 therapists-in-training to video recordings of either a homosexual or heterosexual client-actress. Therapist speaking turns were rated for over-involvement by multiple judges and, across conditions, therapists' average over-involvement score was relatively high when discussing sexual difficulties. However, these findings should be interpreted with caution considering that the raters exhibited only marginal inter-rater reliability on the novel coding system.

Friedman and Gelso (2000) built upon these initial findings and explored the construct of maladaptive approach empirically. Similar to other theorists, they argued that empathically engaged therapists who have lost their objectivity when identifying with patients are just as likely to become over-involved with patient material as they are to withdraw from or avoid it. Based on this idea, Friedman and Gelso developed the Inventory of Countertransference Behavior (ICB), a state measure to describe over- and under-involved CT behavior in a given session. Initially, behaviors that seemed negative (e.g., being critical of the patient) were theorized to reflect therapist withdrawal while seemingly inappropriately supportive behaviors (e.g., befriending the patient) were theorized to reflect over-involvement.

The factors that emerged from Friedman and Gelso's (2000) study, however, were inconsistent with the approach/avoidance paradigm. Rather, these findings suggested that any behavior that meets the therapist's needs is an act of therapist avoidance, but that avoidance can be *positively- or negatively-valenced*. Thus, a seemingly over-involved therapist who engages in excessive self-disclosure is actually exhibiting positively-valenced CT as he withdraws from the patient's experience and defends from his own

anxiety through self-disclosure. Within this paradigm, Friedman and Gelso have defined negatively-valenced CT as therapist behavior that is disapproving, aggressive, or avoidant (e.g., criticizing the patient's decisions; complaining in session; frequently changing the topic), while positively-valenced CT reflects therapist behavior that *seems* supportive (in that it has a positive valence), but has an inappropriate merging, enmeshed, or dependent quality (e.g., offering too much support, reassurance, or advice; talking for the majority of the session; befriending the patient).

CT Behavior and Therapy Outcome and Process

Although positively- and negatively-valenced CT behaviors are understood theoretically as problematic CT manifestations, few studies have examined the effects of these behaviors on therapy outcome. In fact, the effect of positively-valenced CT on posttreatment outcome has not been directly assessed; however, two studies have underscored the potential detrimental effects of positively-valenced CT responses. Hill, Nutt-Williams, Heaton, Thompson, and Rhodes (1996) conducted a qualitative study of therapeutic impasses that resulted in termination. Across interviews with eight therapists, the authors found that in cases where the impasse led to early termination, therapists had frequently felt "drawn in" to care for and rescue their patients. Thus, this study supports the notion that positively-valenced CT responses, although ostensibly supportive, may be avoidant of important patient material and promote premature termination.

Gelso, Hill, Mohr, Rochlen, and Zack (1999) also identified seemingly negative consequences of positively-valenced CT behavior. In a qualitative examination of therapists' transference perspectives in long-term therapy, therapists identified a range of CT responses that they felt impeded their ability to deal effectively with transference.

Therapists reported positively-valenced reactions as frequently as negatively-valenced ones, and they identified these as the source of problems in the work. For example, one therapist noted that he admired his patient for doing things in his life that the therapist could not do himself. The therapist believed that as a consequence, he did not provide the patient enough room to express his own negative feelings, thus creating a countertherapeutic process.

In the only study examining negatively-valenced CT and posttreatment outcome, Hayes, Riker, and Ingram (1997) examined the relationship between therapist avoidance and treatment impact in 12 successful and 8 unsuccessful therapy cases. In the unsuccessful cases, therapist avoidance, measured via supervisor observation, was related to lower ratings of perceived gain from and satisfaction with treatment by patients, supervisors, and therapists. Furthermore, the adverse effect of avoidance on treatment in these less successful cases was proportionate to the amount of negatively-valenced CT that the therapists exhibited. However, no relationship was found between negatively-valenced CT and treatment impact in the successful cases.

In an effort to explain the lack of a relationship between negatively-valenced CT behavior and treatment impact in the successful cases, Hayes et al. (1997) suggested that a strong therapeutic alliance may override the detrimental effect of therapist withdrawal and avoidance. However, the role of the alliance in the relationship between CT behaviors and outcome is unclear. Only one study has explored the direct relationship between CT behaviors and alliance quality. Ligerio and Gelso (2002) had 50 therapist-trainees and their supervisors complete alliance ratings for one of the trainees' patients, and supervisors were also asked to assess their trainees' positively- and negatively-

valenced CT behaviors with the ICB. The authors found that negatively-valenced CT behaviors were related to both supervisor and therapist judgments of weaker global alliances, and positively-valenced CT was related to supervisor judgments of a weaker therapeutic bond. Thus, initial findings support the notion that both positively- and negatively-valenced CT behaviors have a detrimental effect on alliance quality, with the effect of positively-valenced CT being more difficult for therapists themselves to identify. Furthermore, the discrepancy between therapist and supervisor alliance ratings was largest for therapists who demonstrated the most CT behaviors.

CT Management

Although most psychotherapy experts now agree that CT is not inevitably harmful and, in fact, may be potentially helpful, there remains the longstanding belief that both positively- and negatively-valenced CT reactions need to be managed effectively in order for therapy to flourish (Freud, 1910; Gelso & Hayes, 2001; Langs, 1972; Spontnitz, 1979; Winnicott, 1949). In an early description of how to manage CT manifestations, Reich (1951, 1960) proposed that therapists' awareness of their internal affective states and cognitions are integral to this process. She suggested that to deliver effective therapy, therapists must partially identify with their patients, and then must detach from the identification process to establish an objective perspective of the therapeutic exchange. In this process, the therapist's internal experience is an important source of information about the patient's inner world, and the therapist must identify the elements of his experience that belong to the patient. According to Reich (1960), CT occurs at one of two points during the therapeutic exchange; the therapist either fails to engage in the identification process or is unable to detach from the identification process and, thus,

continues to feel as the patient does. In these situations, the therapist becomes blind to the patient's defenses and the focus of therapy orients toward the therapist's conflicts, needs, and defenses. Central to Reich's model is that successful CT management requires therapists to "be alert to our own feelings, stop to investigate them, and analyze what is going on" (p. 392). Before therapists can minimize CT behaviors that interfere with competent functioning, they must become aware of their unresolved conflicts and insightful about CT-based feelings.

Some research supports the notion that therapists' awareness of their own CT-based feelings is central to effective CT management. In a therapy analogue study, Robbins and Jolkovski (1987) posited that therapists who are more aware of CT feelings and who use a theoretical framework to understand these feelings will exhibit lower levels of negatively-valenced CT. Fifty-eight doctoral graduate students completed measures of awareness and theory use, and responses to recordings of a patient-actress suggested that therapists who reported greater awareness of CT feelings withdrew less from the therapeutic relationship. Peabody and Gelso (1982), in another therapy analogue study of 20 therapist-trainees, also found that therapists who were more open to CT feelings were less likely to exhibit negatively-valenced CT behavior when working with seductive female patients. Although awareness of CT feelings and behaviors is regarded in the theoretical literature as a fundamental element of CT management (Gelso & Hayes, 2007; Reich, 1960), research has not provided sufficient support that therapist awareness is a critical component of this process. Given that the theoretical CT literature attaches paramount importance to therapists knowing and understanding their cognitive, affective, and behavioral CT responses to patients, further empirical examination of the role of self-

awareness and self-insight in CT management is important.

In addition to self-awareness, several factors that may influence effective CT management have been hypothesized and tested (Hayes & Gelso, 1991; Latts & Gelso, 1995; Peabody & Gelso, 1982; Robbins & Jolkovski, 1987). Based on empirical and theoretical work, Van Wagoner, Gelso, Hayes, and Diemer (1991) identified *self-insight*, *self-integration*, *empathy*, *conceptualizing skills*, and *anxiety management* as therapist qualities and skills necessary for effective CT management. According to Van Wagoner et al., *self-insight* refers to the therapist's awareness of his own feelings and understanding of their basis and, thus, is synonymous with Reich's (1951, 1960) self-awareness construct described above. *Self-integration* broadly reflects the therapist's psychological health and the extent to which he or she has a stable and intact personality structure. Implicit in this description is the therapist's recognition of boundaries between himself and others. *Empathy* consists of both affective and diagnostic empathy. Affective empathy describes the ability to walk in another's shoes, and diagnostic empathy highlights the therapist's intellectual understanding of another's experience. *Conceptualizing skills* refer to the therapist's ability to make sense of the patient's interpersonal style and dynamics, as well as the therapeutic relationship. Finally, *anxiety management* describes the degree to which the therapist is able to minimize the inhibiting influence of anxiety both in general and during therapy. Van Wagoner et al. synthesized this information into a 50-item measure of CT management, the Countertransference Factor Inventory (CFI), which has been demonstrated to have good content (Hayes, Gelso, Van Wagoner, & Diemer, 1991) and construct validity (Van Wagoner et al., 1991).

Upon closer examination, however, the CFI has two major drawbacks (Latts, 1997). First, items within the anxiety management, empathy, and conceptualizing subscales lack the necessary coherence to reflect accurately the underlying constructs as they relate specifically to CT management. For example, only two of the original conceptualizing skills items focus on the therapy relationship; the remaining items examine the therapist's use of theory to understand the patient's presenting issues in general. Items such as these were rated by experts only to be *somewhat* important in CT management (Hayes et al., 1991). Second, the CFI measures general therapist characteristics that seem related to CT management (e.g., "The therapist tends not to be troubled by anxiety") rather than how the therapist behaves with regard to therapy specifically (e.g., "The therapist is able to deal effectively with anxiety when seeing clients"). Thus, the measure identifies *correlates* of effective CT management rather than its *constituents*. In an effort to capture the intended clinical meaning behind the factors, the CFI has been revised to a 40-item measure reflecting therapy-specific behaviors and attitudes that comprise effective CT management (Latts, 1997).

CT Management and CT Behaviors

The relationship between global management abilities and CT behaviors remains unclear. In an analogue study, Gelso et al. (1995) examined therapists' verbal responses to a videotape of a lesbian patient-actor discussing relationship and sexual problems and found no significant relationship between global therapist management abilities and negative CT behavior. However, Friedman and Gelso (2000) examined supervisor-reported CT behavior in treatment-as-usual (TAU) and found that therapists with greater global management abilities engaged in fewer positively- and negatively-valenced CT

behaviors. Yet, in an examination of the relationship between supervisor-rated CT management and CT behavior in 20 therapy dyads, Hayes et al. (1997) found that only greater empathy and self-integration were associated with fewer negatively-valenced CT behaviors. Thus, research examining the relationship between CT management ability and CT behaviors has yielded varying results.

CT Management and Therapy Outcome and Process

Although research regarding CT behavior and global CT management is mixed, even less is known about the relationship between CT management and therapy outcome and process. Only one study has directly examined therapists' global CT management abilities and posttreatment outcome. Gelso, Latts, Gomez, and Fassinger (2002) had 32 therapists and supervisors rate the outcome of one case and found a positive relationship between supervisor-rated CT management ability and both therapist- and supervisor-rated outcome. Similarly, only one study has examined the relationship between global CT management abilities and therapy process. Rosenberger and Hayes (2002) examined therapist management ability, alliance quality, and session processes in a single therapy dyad over 13 sessions. Therapist's self-rating of management ability was positively related to patient-rated alliance, as well as therapist- and patient-rated session depth.

There is a similar dearth of research examining the relationship between the role of self-insight in CT management and therapy process; however, two studies suggest that therapists' in-session self-awareness, defined as a momentary recognition of their own general thoughts, emotions, and behaviors, would have a positive effect on the therapeutic alliance. In Nutt-Williams and Fauth's (2005) therapy analogue study, 18 volunteer patients met with therapists for a single therapy session. Therapists completed a

measure of self-awareness, while patients reported on two therapy relationship variables: the degree to which they felt understood, supported, and motivated by their therapist and the therapist's perceived helpfulness. Results indicated that therapist in-session self-awareness was related to more positive patient ratings of the therapy relationship and therapists' overall helpfulness. This result was replicated in Fauth and Nutt-William's (2005) examination of therapists' in-session self-awareness and patients' perception of the therapy relationship and therapy processes across 17 patient-therapist dyads. Although these studies highlight the beneficial effect of therapists' self-awareness on the therapy relationship, the association between the therapeutic alliance and therapists' insight *about CT experiences* as an element of CT management has not been directly examined.

In summary, the literature examining therapists' CT behaviors provides ample support of negatively-valenced CT responses to conflictual patient material, while positively-valenced CT responses that reflect a counterintuitive form of avoidance have only recently been examined empirically. However, the limited research suggests that positively-valenced CT may be as damaging to the therapeutic alliance and therapy outcome as negatively-valenced CT. Furthermore, the detrimental effect of positively-valenced CT on the therapy relationship seems more difficult for therapists to detect than the effect of negatively-valenced CT. Literature describing CT management highlights that therapist self-insight may be a fundamental component of effective management, and the small body of research suggests that it may be associated with fewer CT behaviors, stronger alliances, and superior outcomes. However, empirical examinations of the relationships among self-insight, therapist behaviors, and treatment process and outcome

are in their infancy, and further research is necessary to better understand the nature of these relationships.

Specific Aims

The current study examined the relationship between therapists' CT management ability and the frequency and valence of CT behaviors. Particular attention was paid to therapist self-insight, defined as a therapist's awareness of his own unresolved conflicts and CT-based responses to patients, as a theoretically central CT management factor. Given the limited research on this construct to date, the study examined the role of self-insight in accurately identifying *both* positively- and negatively-valenced CT. Because even fewer studies have examined how self-insight influences therapy processes, the relationship between therapist self-insight and therapeutic alliance quality also was explored. Considering that individual CT reactions to patients are inevitable aspects of providing therapy, the importance of understanding self-insight as an active element of CT management cannot be understated.

Although the CT literature has illuminated an important therapist factor as it influences therapy process and outcome, the already small body of work is also characterized by several methodological limitations. The majority of studies have typically been conducted with analogue participants; therapists have interacted with audio- or video-recordings of patients or have spent an hour with a non-treatment seeking undergraduate pseudo-patient. Furthermore, contrived, lab-based scenarios have limited examinations of therapist responses; therapists have selected from one of two possible responses, provided a verbal response at a pre-selected moment in a therapy between a patient-actor and a therapist-actor, or responded to non-clinical material. The current

study addressed these limitations by examining therapists' behavior with actual treatment-seeking patients during a course of TAU. Data for the present study was collected from an outpatient mental health clinic affiliated with a doctoral training program. Therapist management abilities were assessed from a current clinical supervisor's perspective and both therapists and supervisors reported on negatively- and positively-valenced CT behaviors. Additionally, alliance quality was rated from the patient's perspective. The specific research questions and related hypothesis are as follows:

Research Question 1: Are there differences in supervisor versus therapist reports of CT behaviors?

Hypothesis 1: Supervisors will report more CT behaviors than therapists, and the discrepancy between supervisor and therapist reports across all participants will be greatest for positive CT behaviors.

Research Question 2: Do therapists with high versus low levels of self-insight into unresolved conflicts and CT-based feelings differ in their report of CT behaviors?

Hypothesis 2: Therapists with high levels of self-insight will report fewer positively- and negatively-valenced CT behaviors than those with low self-insight, thus reflecting therapists' adaptive CT management.

Research Question 3: Do supervisors of therapists with high versus low levels of self-insight into unresolved conflicts and CT-based feelings differ in their report of the therapists' CT behaviors?

Hypothesis 3: Supervisors of therapists with high levels of self-insight will report fewer positively- and negatively-valenced CT behaviors in their supervisees than

those with low self-insight, thus reflecting adaptive CT management.

Research Question 4: Is there a greater discrepancy between supervisor and therapist reports of CT behavior for therapists with high versus low self-insight into unresolved conflicts and CT-based feelings?

Hypothesis 4: The discrepancy between supervisor and therapist reports of CT behavior will be smaller for therapists with high levels of self-insight because of high-insight therapists' ability to observe accurately their own behavior.

Research Question 5: Do patients of therapists with high versus low self-insight report stronger therapeutic alliances?

Hypothesis 5: Patients of therapists with high self-insight will report stronger alliances than patients of therapists with low self-insight.

CHAPTER II

METHOD

Participants

Therapists. Eight doctoral therapist-trainees from the University of Massachusetts-Amherst (UMass) Clinical Psychology Program participated in the current study. Therapists had a mean age of 29.8 years ($SD = 5.8$ years) and were predominantly White (75%). There were equal numbers of men and women. The therapists had a range of 1 to 6 years of graduate training, including two that had received their PhD in related fields and were completing a respecialization in clinical psychology. Most therapists had provided services to a total of 2 to 3 patients; however, two therapists had provided services to approximately 15 patients, and one had worked with over 60 patients. Two therapists had accrued less than 25 hours of individual therapy, four had accrued approximately 100 hours, and two had accrued over 300 hours. Therapists predominantly identified as practicing integrative therapy, with an average rating of 3.8 ($SD = 1.3$) on a 6-point Likert scale, with higher items reflecting greater influence from an integrative perspective. Therapists were also strongly influenced by cognitive ($M = 3.6$; $SD = 1.1$) and behavioral ($M = 3.4$; $SD = 1.3$) approaches.

Patients. Eight adult outpatients (one per therapist) treated in individual psychotherapy at the Psychological Services Center (PSC), an outpatient community training clinic for the UMass Clinical Psychology Program, provided data during TAU

that were used in the current study. The average age of the sample was 32.32 years ($SD = 17.18$ years). Most participants were female (75%), white (75%), and single (50%). Mean monthly income was \$10,700 ($SD = \$8,865$). No data were available for years of education. Presenting primary diagnoses and their frequency were as follows: major depressive disorder ($n = 3$), dysthymic disorder ($n = 1$), generalized anxiety disorder ($n = 1$), and anorexia nervosa ($n = 1$). Two patients were not diagnosed with an Axis I disorder, and no patients were diagnosed with an Axis II disorder. Patients' average Global Assessment of Functioning (GAF) score at intake was 56.3 ($SD = 8.1$).

Supervisors. Four UMass clinical faculty supervisors (three male and one female) participated in the current study. Supervisors provided therapist participants with 1 hr of individual supervision and 1 hr 30 min of group supervision per week, and each supervisor provided data for at least two of the eight supervisees. The supervisors reported having provided supervision for 1 to 30 years and having had supervised 4 to 300 therapists at the time of the study. Supervisors predominantly identified as practicing integrative and cognitive therapy, with average ratings of 3.8 ($SDs = 1.9$ and $.96$, respectively) on a 6-point Likert scale (higher items reflected greater influence from the particular theoretical orientation). Supervisors were also strongly influenced by behavioral ($M = 3.0$; $SD = 1.6$) approaches. The average supervisor age was 47 years ($SD = 12$ years). Three supervisors were White and one identified as mixed race.

Treatment

Patients received TAU at the PSC. Sessions were typically 50 minutes long and delivered weekly. There is no predominant theoretical orientation in the PSC and the use of treatment manuals is not required. Therapists work under the guidance of supervisors

with various theoretical orientations, and group supervision is organized around a specific treatment orientation (e.g., integrative, cognitive, interpersonal). Therapists are encouraged to develop their own integrative therapeutic approach. Across supervisors and treatment orientations, however, the PSC has a particular emphasis on evidence-based practice.

Measures

Therapist/Supervisor Characteristics Form (TCF; SCF). The Characteristics Forms (see Appendixes A and B) were used to assess therapists' and supervisors' demographic, educational, and training information. Using a 6-point Likert scale ranging from 0 ("Not at all") to 5 ("Very Much"), therapists and supervisors indicated how much their practice and supervision is influenced by various theoretical frameworks (i.e., analytic, behavioral, cognitive, humanistic, systems, and integrative).

Patient Diagnosis. The Structured Clinical Interview for *DSM-IV-TR* Axis I Disorders – Clinician Version (SCID-I-CV; First, Spitzer, Gibbon, & Williams, 1997) and the International Personality Disorders Examination (IPDE; Loranger, 1994) were used to assess patients' baseline diagnoses. The SCID-I-CV and the IPDE are widely used semi-structured clinical interviews for assessing Axis I and II pathology, respectively. Diagnostic assessments were conducted by trained graduate assessors.

Countertransference Factor Inventory – Revised (CFI-R; Latts, 1997). The CFI-R (see Appendix C) is a 40-item measure of therapist characteristics and skills that facilitate CT management. Items specifically assess therapists' self-insight, self-integration, anxiety management, empathy, and conceptualization skills. The original 50-item CFI (Van Wagoner et al., 1991) contains items judged by experts to facilitate CT

management (Hayes et al., 1991) and has successfully differentiated therapists judged to be excellent by their peers from those who are judged to be average (Van Wagoner et al.). Although the original measure focused on therapists' general qualities, the revised measure contains items that reflect therapists' behaviors and attitudes in the context of therapeutic interactions with patients. Supervisors rated therapists on each item on a 5-point scale from 1 ("Strongly Disagree") to 5 ("Strongly Agree"), and higher scores reflect better CT management ability. Internal consistency for the entire CFI-R has been estimated at .94, and Cronbach's alphas for the subscales range from .79 to .90 (Latts, 1997). The internal consistency of the self-insight subscale in the current study was estimated at .84, thus demonstrating good reliability. The CFI-R has also been shown to correlate positively with supervisor-rated effectiveness and therapy outcome (Gelso et al., 2002).

Inventory of Countertransference Behavior (ICB; Friedman & Gelso, 2000).

The ICB (see Appendix D) is a 21-item measure of therapists' in-session countertransference behavior. In addition to the total score, the ICB contains two subscales: positively- and negatively-valenced CT behaviors. Positively-valenced CT behaviors are those that seem supportive, but have a dependent or enmeshed quality, while negatively-valenced CT behaviors are those that are punitive, aggressive, or avoidant. Both positively- and negatively-valenced CT reflects therapist avoidance of important issues in treatment. The ICB was completed by therapists and supervisors, and behaviors were rated from 1 ("little or no extent") to 5 ("a great extent"), with higher scores reflecting more CT behavior. Self-rated reliability for the positive and negative CT subscales in the current study was estimated at .62 and .77, respectively. Supervisor-rated

reliability for the positive and negative CT subscales was estimated at .63 and .76, respectively. Because the marginal reliability estimates for the positive CT subscales are plausibly a function of the small sample, it is important to note that the internal consistency of the positive and negative subscales have been previously estimated at .74 and .81, respectively (Freidman & Gelso, 2000).

Working Alliance Inventory – Short Form (WAI; Horvath & Greenberg, 1989). The WAI (see Appendix E) is a 12-item self-report measure that assesses patient-therapist relationship quality. The patient version was used for the current study. Based on Bordin's (1979) alliance conceptualization, the WAI is comprised of three subscales: the therapeutic bond, agreement on therapy goals, and agreement on therapy tasks. Items are rated from 1 ("Never") to 7 ("Always") with higher scores reflecting stronger perceived alliances. Total WAI scores were used for the current study. The internal consistency of the total score for the present study was low (Chronbach's alpha = .20). However, given that the WAI total score has been shown to possess high internal consistency in previous studies (Chronbach's alpha = .93; Horvath & Greenberg, 1989), the low estimate in the current study is likely a function of the small sample.

Procedure

All therapists with an opening in their caseload at the time the study commenced were eligible to participate. Patients were assigned to participating therapists according to customary PSC procedures, and a trained assessor conducted an initial evaluation, including the administration of the SCID-I-CV and the IPDE. Following the initial evaluation and case assignment, therapists began TAU under supervisor guidance.

After supervisors observed 10 to 15 minute video segments of at least four

therapy sessions across a given therapist's caseload, both therapists and supervisors completed their respective Characteristics Form and supervisors also completed the CFI-R regarding their supervisee. After sessions five, six, and seven, both therapists and supervisors completed the ICB; therapists completed the measure immediately after meeting with the patient, while supervisors first viewed the therapy video recording in its entirety to rate the therapist's CT behavior. Both therapists and supervisors typically completed the ICB prior to meeting for their next supervision session. Although no formal training on identifying CT behavior was provided, each therapist-supervisor dyad met with the primary investigator to discuss the ICB in terms of deviance from therapists' baseline behaviors and to clarify questions. As per standard PSC procedures, patients completed the WAI after the seventh session.

Based on supervisors' ratings of therapists' self-insight on the CFI-R, two groups of therapists were selected for data analysis: the four with the highest and the four with the lowest levels of self-insight. None of the supervisors, therapists, or patients were informed of the purpose of the research until the study was completed.

Data Analysis

Positively- and negatively-valenced CT scores were calculated from both therapists' and supervisors' perspectives by averaging ratings across the three selected sessions. All research questions involve a between group comparison. For question 1, the independent variable was rater perspective (supervisor vs. therapist) and the dependent variable was CT behavior (positive and negative). Discrepancy scores between therapist and supervisor ratings of CT were created by subtracting one score from the other at each time point and averaging these differences within each valence category. For questions 2

and 3, the independent variable was group membership (low vs. high insight) and the dependent variable was CT behavior (positive and negative). For question 4, the independent variable was group membership (low vs. high insight) and the dependent variable was a discrepancy score (calculated as noted above) in supervisor- vs. therapist-rated CT behavior. Finally, for question 5, the independent variable was group membership (low vs. high insight) and the dependent variable was alliance quality. Because of the small sample size and limited statistical power of this study, between-group analyses were limited to effect size estimates using the formula: $(\text{mean of Group 1} - \text{mean of Group 2}) / \text{pooled standard deviation}$ (d ; Cohen, 1988).¹ Confidence intervals around the effect size were also calculated.

¹ Despite the decision to focus on effect size estimates, between-groups inferential statistics (i.e., t -tests) were conducted. As expected, no analyses produced statistically significant differences.

CHAPTER III

RESULTS

Group Selection

The eight participants were equally divided into relative low and high self-insight groups. Self-insight scores for all eight participants ranged from 21 to 34 with an average of 27.5 ($SD = 4.3$). The average self-insight scores for the high- and low-insight groups were 30.75 ($SD = 2.75$) and 24.25 ($SD = 2.75$), respectively.

Analyses

The first question focused on whether supervisors would report more CT behaviors than therapists. Table 1 presents the means, standard deviations, and between group effect sizes with confidence intervals for positive, negative, and total CT behavior. Counter to my hypothesis, there was a medium negative effect size ($d = -.56$) for total CT behavior, suggesting that therapists tended to report *more* CT behaviors than supervisors. The between group difference for positive CT behaviors approached a large effect ($d = -.77$) and the between group difference for negative CT behaviors approached a medium effect ($d = -.46$). When examining the discrepancy between therapist and supervisor reports, no between group effects were found with regard to CT valence (positively-valenced CT [$M = -2.19$; $SD = 3.95$]; negatively-valenced CT [$M = -1.94$; $SD = 4.04$]; $d = -0.07$).

The second question focused on whether therapists with high versus low levels of self-insight would differ in their own report of CT behaviors. Table 2 presents the means,

standard deviations, and between group effect sizes with confidence intervals for therapist-rated positive, negative, and total CT behavior. Counter to my hypothesis, there was a medium positive effect size ($d = .56$) for total CT behavior, suggesting that high insight therapists tended to report *more* CT behaviors than low insight therapists. The between group difference for positive CT behaviors had a small effect ($d = .20$) and the between group difference for negative CT behaviors approached a medium effect ($d = .47$).

The third question focused on whether therapists with high versus low levels of self-insight would differ in their supervisor's report of CT behaviors. Table 3 presents the means, standard deviations, and between group effect sizes with confidence intervals for supervisor-rated positive, negative, and total CT behavior. Counter to my hypothesis, there was a small positive effect size ($d = .16$), suggesting that high insight therapists' supervisors tended to report *more* CT behaviors than low insight therapists (albeit to a negligible degree). The between group difference for positive CT behaviors approached a medium effect ($d = .45$) and the between group difference for negative CT behaviors had a small effect ($d = .20$).

The fourth question focused on whether there would be greater discrepancy between supervisor reports and self-reports of CT behavior for therapists with high versus low self-insight. Comparisons between high and low insight groups with regard to the discrepancy between therapist and supervisor reports of CT found no effects (high-insight group discrepancy [$M = -2.50$; $SD = 4.78$]; low-insight group discrepancy [$M = -2.46$; $SD = 5.98$]; ($d = 0.007$). Thus, no support was provided for the idea that high-insight therapist ratings would be more consistent with supervisor ratings as compared to low-

insight therapist ratings.

The fifth and final question focused on whether patients of therapists with high versus low insight would report higher quality therapeutic alliances. The alliance means for high insight and low insight groups were 62.5 ($SD = 5.5$) and 59.5 ($SD = 2.5$), respectively. Consistent with my hypothesis, there was a medium positive effect size ($d = .71$; $CI = - 0.80, 2.03$), suggesting that patients of high insight therapists tended to report stronger alliances than low insight therapists.

CHAPTER IV

DISCUSSION

The present preliminary study examined the frequency and valence of therapists' CT behaviors and therapeutic alliance quality as a function of therapist self-insight, a theoretically central CT management factor. Through a series of between group comparisons, several small to medium effects were found. First, therapists unexpectedly reported more total, positive, and negative CT behaviors than their supervisors, and the expected differences in supervisor and therapist reports of CT behavior by CT valence were not found. Second, when the relationship between self-insight and CT behaviors was examined from the therapist perspective, high-insight therapists were unexpectedly found to report more positively- and negatively-valenced CT than the low-insight therapists. Third, when the relationship between self-insight and CT behaviors was examined from the supervisor perspective, supervisors were unexpectedly found to report more positively- and negatively-valenced CT for high-insight therapists than for low-insight therapists. Fourth, the expected finding that therapists' self-ratings of CT behavior would be more consistent with supervisor ratings for high-insight versus low-insight therapists was not found. Finally, as expected, patients of therapists with higher levels of self-insight reported stronger therapeutic alliances than patients of therapists with lower levels of insight.

Because CT behavior can be driven by unconscious conflicts and/or powerful interpersonal and affective pulls that may be difficult to notice and to disembed from, I

hypothesized that supervisors would report more therapist CT behaviors than therapists themselves. However, the findings suggested the opposite; across positive, negative, and total domains, therapists self-reported more CT behavior than their supervisors. Although these finding needs to be interpreted with great caution given the small sample size and preliminary nature of the study, it may have several possible meanings. First, therapists, in their direct report of CT behavior immediately following a session, may have a better understanding than supervisors of when their own behavior is based in a CT process. Through direct interactions with the given patient, therapists establish a specific and unique repertoire of behaviors with that patient. Thus, therapists may be able to identify subtle deviations from this patient-specific pattern of behavior while supervisors may be evaluating therapists' behaviors with a specific patient based on a global understanding of how the therapist typically behaves. This effect was strongest for positively-valenced CT behaviors, suggesting that therapists may especially have a clearer understanding than their supervisors of when their approach behaviors are in the service of avoidance rather than elaboration. Second, in their role as teachers, supervisors may be less likely to see beginning therapists' behaviors as CT-based. That is, they may be more focused on helping the therapist become comfortable with a wide repertoire of behaviors and may encourage them to experiment with different therapeutic strategies. Even recognized problem behaviors may be ascribed to natural growing pains as opposed to being CT-linked. In a related sense, supervisors, perhaps through their own defense operations to maintain a sense of being a competent clinician and teacher, may be motivated unconsciously to see less CT behavior than may actually be present in the session. Third, therapists' theoretical orientations may have affected their ability to judge accurately

behavior on the CT dimensions. Specifically, therapists practicing primarily from a cognitive-behavioral approach reported that they had difficulty completing the behavior measures. Because the therapist sample was strongly influenced by cognitive and behavioral approaches, higher therapist ratings of CT behavior may reflect a less nuanced understanding of the behaviors of interest, as well as when these behaviors become problematic.

When examining therapists' ability to manage their CT behavior, I hypothesized that therapists with higher levels of self-insight would be able to observe and respond internally to their CT-based thoughts and feelings, and consequently, would engage in less CT behavior than low-insight therapists. However, the findings suggested that across positive, negative, and total domains, high insight therapists tended to report *more* CT behaviors than low insight therapists. Although counter to my hypothesis, this finding is consistent with a growing body of literature that suggests that therapists who are more mindful are able to recognize, without judgment, the full range of their reactions to clients (Fauth et al., 2007; Morgan, 2005; Nutt-Williams, 2008). Thus, high-insight therapists may be better than low-insight therapists at noticing and reporting when they engage in CT behaviors. These findings do not necessarily suggest that low-insight therapists engage in less CT behavior; rather, low-insight therapists may not be reporting when their behavior is CT-based as accurately as high-insight therapist. In this event, these findings may suggest that self-awareness and self-insight are distinct, but related constructs; non-defensive self-awareness may be a precursor to therapists' use of self-insight as a CT management strategy. Given the small sample size and preliminary nature of the study, this interpretation is offered tentatively and cautiously.

Based on the idea that high-insight therapists would be able to manage their internal processes and refrain from displaying CT-based behaviors in sessions, I hypothesized that the supervisors of high-insight therapists would report less CT behaviors than the supervisors of low-insight therapists. Counter to my predictions, supervisors of high-insight therapists reported *more* total, positively-valenced, and negatively-valenced CT behaviors. Although high-insight therapists may be able to report their behavior more accurately than low-insight therapists, the convergence of therapist and supervisor reports is more perplexing. However, it is possible that supervisors perceive more CT behavior in their high insight supervisees because they perceive these therapists as using it effectively as an intervention and, thus, are more likely to attend to it in supervision. On the other hand, supervisors' perception of less CT behavior with low insight therapists may reflect that they do not see such behavior being used effectively by these therapists as an intervention and, thus, it is less salient. However, this does not suggest that low-insight therapists do not engage in CT behavior. Rather, low-insight therapists' internal CT reactions and in-session behavioral manifestations may be examined with less scrutiny by both the therapist and the supervisor as a function of them not being viewed as effective intervention points.

Based on the idea that high-insight therapists would engage in less CT behaviors than low-insight therapists, I hypothesized that the patients of high-insight therapists would report stronger therapeutic alliances. Although the alliance findings were in the expected direction, the composite of the present findings suggest that it may be high-insight therapists' *use* of CT thoughts and feeling, rather than their eradication, that is related to alliance quality. There are several plausible mechanisms through which this

may occur. First, high-insight therapists' openness to a fuller range of internal experiences may facilitate an empathic stance and allow patients to feel more comfortable discussing the full range of their own thoughts and feelings. Second, high-insight therapists' use of their internal experiences to inform hypothesis about patients may provide implicitly a model for patients to explore their own past and present experiences as they relate to the content of the session. This approach to CT allows the patient-therapist dyad to move away from an expert model towards one of mutual exploration and connection and may strengthen the relationship. Third, therapists who are more insightful may be able to anticipate better how a given experience or comment will influence a patient and can thus position themselves to respond more appropriately. In contrast, therapists who display lower levels of self-insight may lose the ability to think flexibly when patients' experiences are similar to their own and, thus, CT would interfere with their ability to engage fully with their patients. Although not explicit, this dynamic might decrease the quality of the patient-therapist relationship. Given the small sample size and low reliability of the WAI in the current study, these interpretations are offered cautiously.

Taken together, the present results suggest that therapists may identify when their reactions are based in CT more readily than their supervisors, that CT behavior is observed by high-insight therapists and their supervisors with greater frequency than low-insight therapists and supervisors, and that high-insight therapists tend to have stronger alliances with their patients. This pattern of findings may reflect high-insight therapists using their insight into their CT-based feelings to inform interventions and establish stronger therapeutic alliances with their patients. In turn, the effective use of CT-feelings

and behaviors may make CT behaviors more salient to both therapists and supervisors. These process findings support the growing trend in CT research to move beyond traditional ideas that CT behavior is associated with less effective treatment and that therapists must mitigate the deleterious effect of CT on the therapy process. Rather, CT can be understood as an unavoidable element of the psychotherapy endeavor that can be used, under the right conditions, to improve the alliance, and perhaps indirectly, treatment outcome.

Several limitations characterize the current study. Statistically, the study has limited power because of the small sample size. Thus, all findings must be interpreted with caution; these results highlight promising trends that must be examined with greater methodological rigor. Additionally, the WAI and the positively-valenced CT scale on the ICB demonstrated low and marginal reliabilities, respectively. Although these estimates are likely a function of the small sample, findings related to positively-valenced CT and the therapeutic alliance must be interpreted with additional caution. Furthermore, the effect size analysis fails to account for the non-independence of variance of supervisors rating multiple therapists. Thus, future analyses with a larger sample must account for these variance trends in nested data. Finally, there was a limited range of therapist self-insight; although two groups of insight-level were identified, there was limited distinctiveness between insight groups. Thus, future research will need to identify therapists with very high and very low insight levels or will need to consider alternative ways to examine insight as it relates to in-session CT behavior.

Conceptually, several limitations emerged as well. With respect to the measurement of self-insight, there appears to be a distinction between momentary self-awareness and

self-insight that is not measured in the CFI-R. Furthermore, supervisors who practiced from a cognitive-behavioral approach described difficulty completing the CFI-R, despite describing the measure as reflective of phenomena relevant to the practice of psychotherapy regardless of theoretical orientation. Thus, future studies may need revise the CFI-R or create a new measure that both identifies the distinction between momentary self-awareness and self-insight and that explores the CT construct and self-insight from a transtheoretical framework. Future studies could also use multiple measures that examine self-insight as described within various theoretical approaches to create a self-insight composite score. Another related issue is the identification of CT behavior. Although the ICB attempts to measure CT behavior as a deviation from a therapist's typical behavior, it is unclear if a therapist's actions during a session were motivated by a CT trigger. Thus, future studies should identify individual therapist "hot spots" and examine the relationship between self-insight, CT feelings and behaviors, and the therapeutic alliance during sessions when a CT hot spot is triggered. Finally, both therapists and supervisors are invested in the therapists' performance and the outcome of the case. Thus, future studies should also attempt to compare therapist/supervisor perspectives with independent observer ratings to distinguish between reports of CT versus actual CT behavior.

As the study of CT continues, it will be important to identify *how* therapists of various theoretical orientations use their internal experiences to facilitate their understanding of their patients' experience and to build stronger therapy relationships. A better understanding of this process might reveal teachable strategies that would enable beginning therapists learn how to accept the inevitability of CT reactions and to identify

how they personally move through their process of reflection and intervention development.

Table 1: CT Behavior by Rater

CT Behavior	Therapist (<i>n</i> = 8)		Supervisor (<i>n</i> = 8)		ES (95%CI)
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
Positive CT	16.81	3.30	14.63	2.28	-.77 (-1.74, 0.28)
Negative CT	20.19	3.85	18.25	4.57	-.46 (-1.42, 0.56)
Total CT	30.90	4.89	28.42	3.83	-.56 (-1.53, 0.46)

Note. ES = between-group effect size; CI = confidence interval.

Table 2: Therapist-Rated CT Behavior by Insight Level

CT Behavior	High Insight (<i>n</i> = 4)		Low Insight (<i>n</i> = 4)		ES (95%CI)
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
Positive CT	17.17	3.94	16.46	3.10	.20 (-1.74, 0.28)
Negative CT	21.13	3.50	19.25	4.48	.47 (-0.99, 1.81)
Total CT	31.25	5.06	30.54	5.46	.56 (-1.27, 1.50)

Note. ES = between-group effect size; CI = confidence interval.

Table 3: Supervisor-Rated CT Behavior by Insight Level

CT Behavior	High Insight (<i>n</i> = 4)		Low Insight (<i>n</i> = 4)		ES (95%CI)
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
Positive CT	15.17	2.08	14.09	2.66	.45 (-1.01, 1.79)
Negative CT	18.75	2.60	17.75	6.44	.20 (-1.21, 1.57)
Total CT	28.75	4.01	28.01	4.22	.16 (-1.25, 1.53)

Note. ES = between-group effect size; CI = confidence interval.

Figure 1- Therapist Characteristic Form

Age	_____	Highest Current Degree	_____
Gender	_____	Years in Training	_____
Ethnicity	_____	Total Clinical Hours	_____
Race	_____	Total # of Adult Patients	_____

How much is your current therapeutic practice guided by each of the following theoretical frameworks?

	Not at all					Very Much
Analytic / Psychodynamic	0	1	2	3	4	5
Behavioral	0	1	2	3	4	5
Cognitive	0	1	2	3	4	5
Humanistic / Experiential	0	1	2	3	4	5
Systems Theory	0	1	2	3	4	5

Please describe your theoretical orientation in the space below:

To what extent do you regard your orientation as Eclectic / Integrative?

Not at all					Very Much
0	1	2	3	4	5

Figure 2- Supervisor Characteristic Form

Age	_____	Highest Current Degree	_____
Gender	_____	Experience Level	_____
Ethnicity	_____	Years of Clinical Practice	_____
Race	_____		

How much is your current therapeutic practice guided by each of the following theoretical frameworks?

	Not at all					Very Much
Analytic / Psychodynamic	0	1	2	3	4	5
Behavioral	0	1	2	3	4	5
Cognitive	0	1	2	3	4	5
Humanistic / Experiential	0	1	2	3	4	5
Systems Theory	0	1	2	3	4	5

Please describe your theoretical orientation in the space below:

To what extent do you regard your orientation as Eclectic / Integrative?

Not at all					Very Much
0	1	2	3	4	5

Figure 3 - Countertransference Factor Inventory-Revised

Please rate the therapist you supervise on the items below using the following five point scale. If you strongly disagree with the statement, circle the number '1'; if you strongly agree, circle the number '5'. Use the numbers in between to describe the variations between these extremes.

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
The therapist:					
1. is able to distinguish between reactions that are “pulled” from him/her by the client and those that stem from his/her own areas of unresolved conflict.	1	2	3	4	5
2. has a stable sense of identity which is reflected in his/her therapeutic work.	1	2	3	4	5
3. is often aware of personal areas of unresolved conflict which may be touched upon while doing therapy.	1	2	3	4	5
4. usually restrains him/herself from excessively identifying with the client’s conflicts.	1	2	3	4	5
5. is able to identify with the client’s feelings and still maintain the capacity to disengage from the identification process.	1	2	3	4	5
6. is often aware of feelings in him/her elicited by clients.	1	2	3	4	5
7. understands the background factors in his/her life that have shaped his/her personality and uses this understanding in the therapeutic work.	1	2	3	4	5
8. at the appropriate times, stands back from a client’s emotional experience and tries to understand what is going on with the client.	1	2	3	4	5

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
The therapist:					
9. is able to use his/her reactions to clients as clues to clients' feelings or dynamics.	1	2	3	4	5
10. is comfortable in the presence of clients' strong feelings.	1	2	3	4	5
11. is able to comfort him/herself when feeling anxious during sessions.	1	2	3	4	5
12. generally remains emotionally attuned with the client when otherwise feeling uncomfortable during sessions.	1	2	3	4	5
13. is often aware of his/her personal impact on clients.	1	2	3	4	5
14. makes an effort to emotionally identify with the client when the client discusses material that is uncomfortable for the therapist-trainee.	1	2	3	4	5
15. effectively distinguishes between the client's needs and his/her own needs.	1	2	3	4	5
16. is generally able to step back and cognitively process his/her own reactions to clients.	1	2	3	4	5
17. is often aware of fantasies in him/her triggered by client material or affect.	1	2	3	4	5
18. usually comprehends how his/her feelings influence him/her in the therapy.	1	2	3	4	5
19. can usually identify dynamics of the counseling relationship.	1	2	3	4	5
20. lacks a theoretical understanding of the therapeutic work to help guide his/her interventions with clients.	1	2	3	4	5

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
The therapist:					
21. is able to deal effectively with his/her own anxiety when seeing clients.	1	2	3	4	5
22. possesses psychological balance which is reflected in his/her therapeutic work.	1	2	3	4	5
23. is able to contain his/her anxiety in the presence of clients' strong emotions.	1	2	3	4	5
24. tends to empathize so much with the client's feelings that the client is actually impeded from growing.	1	2	3	4	5
25. can usually identify with the client's inner experience.	1	2	3	4	5
26. generally fails to convert his/her feelings during sessions into conceptualizations that are useful in guiding the work.	1	2	3	4	5
27. has the capacity to stand back from his/her own emotional experience and observe what is going on with him/herself with regard to clients.	1	2	3	4	5
28. is unable to alternate easily between emotional identification with the client and objective understanding.	1	2	3	4	5
29. usually recognizes his/her own negative feelings towards clients.	1	2	3	4	5
30. is comfortable with self when working with clients.	1	2	3	4	5
31. is comfortable being close with clients.	1	2	3	4	5
32. effectively recognizes the boundaries between self and clients.	1	2	3	4	5

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
The therapist:					
33. often becomes immobilized by anxiety when working with clients, not knowing how to respond or intervene.	1	2	3	4	5
34. is perceptive in his/her understanding of clients.	1	2	3	4	5
35. usually manages his/her need for approval with clients.	1	2	3	4	5
36. possesses a conceptual understanding of the therapeutic work which enables him/her to make sense of reactions to clients.	1	2	3	4	5
37. allows his/her own personal problems or conflicts to interfere with the therapeutic work.	1	2	3	4	5
38. tends to deal with his/her anxiety in the presence of strong client emotions by disengaging from the work.	1	2	3	4	5
39. often conceptualizes his/her role in what transpires in the counseling relationship.	1	2	3	4	5
40. is not usually aware of the motivation behind his/her behavior with clients.	1	2	3	4	5

Figure 4- Inventory of Countertransference Behavior

Please rate the therapist's reaction to the patient during the session you observed on the following five point scale. If the therapist displays the following behaviors to little or no extent, circle the number '1'; if they display the behavior to a great extent, circle the number '5'. Use the numbers in between to describe the variations between these extremes.

	little or no extent		moderate extent		great extent
The therapist:					
1. colluded with the patient.	1	2	3	4	5
2. rejected the client.	1	2	3	4	5
3. oversupported the patient.	1	2	3	4	5
4. befriended the patient.	1	2	3	4	5
5. was apathetic toward the patient.	1	2	3	4	5
6. behaved as if she or he were "somewhere else."	1	2	3	4	5
7. talked too much during the session.	1	2	3	4	5
8. frequently changed the topic.	1	2	3	4	5
9. was critical of the patient.	1	2	3	4	5
10. spent time complaining during session.	1	2	3	4	5
11. treated the client in a punitive manner.	1	2	3	4	5
12. inappropriately apologized to the patient.	1	2	3	4	5
13. acted submissive with the patient.	1	2	3	4	5
14. acted in a dependent manner.	1	2	3	4	5
15. seemed to agree too often with the patient	1	2	3	4	5

16. inappropriately took on an advising tone with the patient.	1	2	3	4	5
17. distanced him/herself from the patient.	1	2	3	4	5
18. engaged in to much self-disclosure.	1	2	3	4	5
19. behaved as if he / she were absent.	1	2	3	4	5
20. inappropriately questioned the patient's motives.	1	2	3	4	5
21. provided to much structure.	1	2	3	4	5

Figure 5- Working Alliance Inventory- Short Form

On the following page there are some sentences that describe some of the different ways a person might think or feel about his or her therapist. Please complete these ratings in terms of your experience with your therapist during the most recent session. As you read the sentences, mentally insert the name of your therapist in place of the _____ in the text.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

Use the above seven point scale for each item. If the statement describes the way you always feel (or think), circle the number '7'; if it never applies to you, circle the number '1'. Use the numbers in between to describe the variations between these extremes. This questionnaire is confidential; your therapist will not see your answers. Work fast; your first impressions are the ones we would like to see. Please don't forget to respond to every item.

- _____ 1. _____ and I agree about the things I will need to do in therapy to help improve my situation.
- _____ 2. What I am doing in therapy gives me new ways of looking at my problem.
- _____ 3. I believe _____ likes me.
- _____ 4. _____ does not understand what I am trying to accomplish in therapy.
- _____ 5. I am confident in _____'s ability to help me.
- _____ 6. _____ and I are working on mutually agreed upon goals.
- _____ 7. I feel that _____ appreciates me.
- _____ 8. We agree on what is important for me to work on.
- _____ 9. _____ and I trust one another.
- _____ 10. _____ and I have different ideas on what my problems are.
- _____ 11. We have established a good understanding of the kind of changes that would be good for me.
- _____ 12. I believe the way we are working with my problem is correct.

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