COUNTERTRANSFERENCE AWARENESS AND THERAPISTS' USE OF PERSONAL THERAPY

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DISSERTATION ABSTRACT

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This study explored the relationship between therapists' personal therapy and their countertransference management and awareness. Participants consisted of fifty-seven interns, postdoctoral interns, and ABD clinicians and their supervisors at APA-accredited internship sites. Supervisees completed a brief experimenter-designed survey inquiring about an impactful personal therapy experience they had, if they had sought therapy after beginning their graduate training. This survey included an open-ended question regarding the impact of personal therapy on their clinical practice. Supervisors rated their supervisees using the Countertransference Factors Inventory (CFI), a 21-item questionnaire using a Likert-scale to measure aspects of countertransference management, including self-insight.

Data analysis focused on the hypotheses that having experienced personal therapy would be correlated to both higher CFI scores and self-insight subscale scores. It was also hypothesized that longer therapy would correlate positively to higher scores on the CFI and the self-insight subscale in particular.

Having experienced personal therapy since beginning graduate training was not found to be related to any aspect of countertransference management as measured by the CFI, nor was the length of the therapy. Additional exploratory analyses also did not reveal any significant relationships. Findings from the open-ended question revealed that therapists' perception of the influence of their personal therapy on their clinical work were almost uniformly positive. Several themes emerged, including increased self-awareness, greater empathy, and heightened awareness and appreciation of transference and countertransference processes.

With exception of the open-ended responses, which are consistent with existing literature on therapists' perceptions of their personal therapy, the findings in this study are divergent from previous empirical investigations in the areas of countertransference and personal therapy.

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CHAPTER I

INTRODUCTION AND RATIONALE

The purpose of psychotherapy has always been to improve a client's life functioning and satisfaction; this, in essence, is the measure of its value. Research has clearly demonstrated that psychotherapy is effective in alleviating symptoms and bringing about character change (e.g. Buckley, Karasu, & Charles, 1981; Lipsey & Wilson, 1993; Seligman, 1995; Smith, Glass, & Miller, 1980; Wampold, 2000). It is generally accepted that therapists' physical and mental health are prerequisites for therapy to achieve this purpose. The literature points to the importance of therapists' self-care (diet, exercise, etc.), and self-reflection patterns (journaling, supervision, consultation, personal therapy, etc.) in maintaining a healthy level of adjustment (Brady, Guy, & Norcross, 1995; Jennings & Skovholt, 1999; Mahoney, 1997; Norcross, Prochaska, & DiClemente, 1986; Norcross & Prochaska, 1986a; Norcross & Prochaska, 1986b; Norcross, 2000). While much is known about the role of therapy in personal change, we know much less about the influence of therapists' own therapy (commonly referred to as personal therapy) on their effectiveness as clinicians (Macran, Stiles, & Smith, 1999). The question, then, is not whether personal therapy is effective, but whether it is beneficial to therapists' professional functioning.

What we do know is that personal therapy seems to have a significant impact on therapists' *perceptions* of their effectiveness. Among other benefits, therapists report increased empathy, heightened self-awareness and appreciation of its importance in the therapy process, increased awareness of the person of the therapist, awareness of countertransference and transference processes, and increased understanding and tolerance of their clients, as a result of personal therapy (MacDevitt, 1987; Macran, Stiles, & Smith, 1999; Norcross, Strausser-Kirkland, & Missar, 1988; Peebles, 1980; Wiseman & Shefler, 2001). The few studies that have addressed the question of whether the benefits of personal therapy actually translate into better client outcomes have yielded mixed results (Macran & Shapiro, 1998).

Therapists have long been encouraged – if not required – to engage in personal psychotherapy. Since the time of Freud, personal therapy has been seen by many as an integral part of the study of psychotherapy (Freud, 1912/1989). This is particularly true in psychoanalytic traditions, but the notion of personal psychotherapy as valuable to the provision of psychotherapy is embraced by most schools of psychotherapy. The behaviorist school of thought is a notable exception in that it tends to view personal psychotherapy as a possible, but not necessary, adjunct to the study of psychotherapy (Garfield & Kurtz, 1976; Holzman, Searight, & Hughes, 1996). This is also evidenced by the relatively low use of personal therapy by behavior therapists compared to therapists of other theoretical orientations (Norcross, Strausser-Kirkland, & Missar, 1988).

Freud recognized that therapists use their person as an instrument in the therapy process, and that a therapist's 'blind spots' would interfere with the material presented by

the client. Effective therapy would be contingent upon a therapist being aware of, and therefore free of, unconscious resistances so that full conscious and unconscious attention could be given to the patient. This should be accomplished both by personal therapy and then continuous engagement in the process of self-examination (Freud, 1912/1989). The notion of the person of the therapist as central to effective therapy and the consequent need for the therapist to possess adequate mental health have continued to be asserted by the profession since Freud's time (Deutsch, 1985; Garfield & Bergin, 1971; Guy & Liaboe, 1986; Hoyt, 2001; Jennings & Skovholt, 1999; Mahoney, 1987; McConnaughy, 1987; Rogers, 1961/1989).

Freud (1937/1964) also recognized that the continuous exposure to clients' unconscious material provided a need for further therapy, and suggested that therapists re-enter personal therapy periodically throughout their lives. In this way, the instrument of therapy (the therapist) could be maintained by repeated self-examinations that would wash away the residue of clinical work and any unresolved issues that would inevitably emerge throughout the therapist's lifetime. If the instrument were in good shape, so would be the therapy provided.

This emphasis on the therapist's self-awareness was essentially what Freud termed counter-transference (Freud, 1910, as cited in Gelso & Hayes, 1998). The term has been subjected to varying definitions since Freud's description of the phenomenon. Countertransference is now viewed as encompassing all of the therapist's feelings and attitudes toward the client and may take several forms (Kahn, 1997). Kahn (1997) describes these forms: (1) Realistic responses that most people would have in response to the particular client; (2) Responses strictly to the client's transference (the client's

tendencies to both view the therapy relationship in the light of his or her earliest relationships and to attempt to recreate these difficult relationships); (3) Responses to material that is troubling to the therapist due to its triggering anxiety around an unresolved issue; and (4) Characteristic responses of the therapist that she or he would bring to any situation, such as a need to please.

While all of these forms of countertransference are valid, the definition that will be used in this paper will be what Winnicott (1949) referred to as subjective countertransference. This type of countertransference encompasses both responses to material that is troubling to the therapist and characteristic responses of the therapist, as both point to the importance of resolving personal conflicts. This definition also encompasses the notion that countertransference can be expressed in either a positive or negative way, but stems from distorted perceptions regardless (Rosenberger & Hayes, 2002).

The phenomenon of subjective countertransference as defined above is important because it is exactly this type of countertransference that is likely to go undetected by the therapist; it is the type that is most personally threatening. Lack of awareness of unresolved material and characteristics emerging from this type of the countertransference is also likely to make it more difficult to sort out whether one's response to the client is indeed realistic, or whether it is distorted. Several authors have documented the potential dangers of failing to attend to one's countertransference. Therapists might inadvertently avoid, or fail to see the clinical relevance of, certain 'triggering' material. Conversely, they might focus on an area that is not clinically relevant. Unmanaged countertransference might result in the use of clients to vicariously

gratify one's own unmet needs. Therapists might be prone to use subtle cues to influence the client toward a particular course of action. Countertransference might cause therapists to collude with their clients' transference and 'become' the people their clients fear they are. By way of example, therapists who have their own unresolved anger and who are repeatedly subjected to a client's anger and hostility might very well; Gelso & Hayes, 1998; Glickauf-Hughes, 1998; Kahn, 1997; Masterson, 1988; Pipes & Davenport, 1999). Therapists in the midst of negative countertransference are also at risk for communicating to their clients – whether directly or indirectly – that *they* are the ones failing to see what is really going on, thus invalidating their clients' perceptions (Pipes & Davenport, 1999).

Given the potential dangers of failing to develop and/or maintain awareness of one's countertransference, it is surprising that relatively little empirical attention has been devoted to countertransference awareness. One possible reason might be the complexity of countertransference itself and the many varied ways in which it can be manifested (Gelso, Fassinger, Gomez, & Latts, 1995; Gelso & Hayes, 1998). Nonetheless, the study of this phenomenon and its components is clearly relevant to the practice of psychotherapy, as countertransference appears to have a significant impact on the therapy process, and likely ultimately on therapy outcome. There is also a strong possibility that unmanaged countertransference is a precursor to the emotional depletion that characterizes burnout. Finally, the importance of countertransference awareness is underscored by the fact that no one is immune to the existence of hidden and undesired parts of themselves; therapists are human and that is simply the human condition.

Furthermore, there are aspects of both the personal and professional side of psychotherapists' lives that increase the likelihood that they will experience countertransference. Psychotherapists are seemingly often drawn to the field because of their own backgrounds of neglect, trauma, or abuse in their families-of-origin. Several researchers have documented the high rate of childhood abuse, high degrees of parental conflict, and childhood roles as mediators or caretakers in therapists' families-of-origin (Cain, 2000; Elliott & Guy, 1993; Guy, 1987; Guy & Liaboe, 1986a; Henry, Sims, & Spray, 1971; Racusin, Abramowitz, & Winter, 1981). The implication is, of course, that the very people trained to help others work through their woundedness are likely to have histories that might lend themselves to distortions in perceptions of and reactions to clients.

Additionally, therapists are susceptible to experiencing vicarious trauma due to the nature of clinical work (Herman, 1992); the toll the practice of therapy takes on the practitioner has been well documented. Some of the ways in which this is manifested include a reduced emotional involvement in friendships and families, feelings of abandonment, a lack of spontaneity resulting from the indiscriminate application of an interpretive stance, and the emotional depletion of working with more severely disturbed clients (Farber, 1983; Guy, 1987; Guy & Liaboe, 1986b; Kottler, 1993; Sherman, 1999, as cited in Stadler, 2001). A worst-case scenario would be an interaction between these 'risk factors': for example, a therapist with a history of abuse working with an abuse survivor. Between therapists' own unresolved struggles and the sometimes traumatic nature of clinical practice, the likelihood of burnout and subsequent impairment becomes much more plausible (Brady, Guy, & Norcross, 1995; Farber, 1983; Pope & Bouhoutsos,

1986; Sherman, 1999, as cited in Stadler, 2001). Many authors have suggested that personal therapy is a way to avoid burnout and subsequent impairment (Deutsch, 1985; Guy & Liaboe, 1986a; Mahoney, 1997; Norcross, 2000; Pope & Tabachnick, 1994).

It is also important to not overlook the normal developmental transitions and common events that occur over the course of a lifetime. Like other people, therapists often experience marriage, pregnancy, parenthood, divorce, the death of a loved one, and the departure of grown children from the home (Guy, 1987). These events, along with the high rates of personal problems (depression, anxiety, marital difficulties, and so on) that therapists experience further complicate and increase the likelihood that countertransference will develop (Guy, Poelstra, & Stark, 1989; Norcross & Aboyoun, 1994; Pope & Tabachnick, 1994; Thoreson, Miller, & Krauskopf, 1989).

While psychotherapy is known to be generally effective, it has been suggested that personal therapy is also one way to specifically help therapists regulate their countertransference reactions (Hayes, Gelso, Van Wagoner, & Diemer, 1991; Martin McIntyre & Schwartz, 1998; Prochaska & Norcross, 1983; Wampler & Strupp, 1976). Therapists themselves have reported an increase in self-awareness and in the awareness of the importance of countertransference issues as a result of their personal therapy experiences (MacDevitt, 1987; Macran, Stiles & Smith, 1999; Norcross, Strausser-Kirkland, & Missar, 1988; Wiseman & Shefler, 2001). MacDevitt (1987) examined the relationship between personal therapy and the propensity of practicing therapists to engage in self-examination, which he labeled countertransference awareness. He found that therapists who had received personal therapy were found to have higher levels of countertransference awareness. Furthermore, the longer the history of personal therapy,

the higher the therapist's level of countertransference awareness. In other words, it was not merely the process of engaging in personal therapy that seemed to facilitate the awareness, but also the number of hours or sessions of therapy. His study was the first to examine the relationship between countertransference awareness and personal therapy.

This study investigated whether personal therapy is related to countertransference awareness when providing psychotherapy; countertransference awareness was assessed using ratings by others. Specifically, it was expected that engaging in personal therapy would increase awareness of countertransference; thus, it was hypothesized that those who had engaged in personal therapy since beginning their clinical training program would show greater countertransference awareness, as reported by MacDevitt (1987); Macran, Stiles & Smith (1999); Norcross, Strausser-Kirkland, & Missar (1988); and Wiseman & Shefler (2001). It was further hypothesized that the number of hours of personal therapy received would be related to the level of countertransference awareness. Additionally, since most information related to the impact of personal therapy on the therapist has been obtained from either therapists-in-training at the practicum level or from advanced therapists, this study examined the experiences of pre-doctoral interns, and clinicians who had completed internship but were not yet licensed psychologists. This group was chosen not simply because of its uniqueness from other groups of clinicians, but also because interns and those who have completed internship are in a unique position to have both the experience to know which conflict areas are likely to be triggered when doing therapy, and to still have supervision to encourage self-reflection of these areas. Since they are not beginning therapists, they are less likely to have the anxiety that frequently accompanies this stage of clinical training; this is helpful when

attempting to determine what is countertransference and what are normative sequelae of beginners' anxiety.

CHAPTER II

REVIEW OF RELEVANT LITERATURE

Psychotherapists' Personal Problems and Use of Personal Therapy

Like other people, therapists have problems. Unlike other people, their mental health is prerequisite to not only doing good work but to also avoid doing harm. They must be well-adjusted and maintain emotional stability in order to be effective and to remain ethical; otherwise, their work, and their clients, suffer. While intuitively it would seem that all therapists would try out their own product – whether out of curiosity or from personal difficulties - this is not always the case. Understanding their help-seeking behaviors is therefore important. This section will review several studies that investigate psychotherapists' levels of personal distress and impairment, as well as various factors related to their use of therapy.

Kaslow and Friedman (1984) conducted semi-structured interviews with 14 clinical psychology students currently in therapy. Most stated they were in psychodynamic psychotherapy. They found that most of their sample entered therapy for personal reasons, specifically seeking help with the adjustment to the newness and stress of graduate school. Psychotherapy fees were found to be an obstacle to obtaining therapy. Additionally, the reality of multiple relationships often encountered when seeking therapy– such as therapists' having outside knowledge of significant people in

their lives – sometimes inhibited what students felt they could safely bring up in session due to real or imagined loyalty conflicts between therapist and trainee with regard to these other people.

Holzman, Searight, and Hughes (1996) explored the use of personal psychotherapy among 1,018 graduate students in clinical psychology programs. Seventy four percent reported having sought therapy at some point in their lives, with an average of almost 80 sessions. Over half had been in individual therapy more than once. The average number of sessions for this latter group was 130. Students' beliefs about personal therapy's effectiveness varied as a function of theoretical orientation: when asked about personal therapy's effectiveness in managing countertransference issues, 73% of students with psychodynamic orientations assigned a rating of 1(where 1=yes ad 7=no) as compared to only 28% of those with a cognitive-behavioral orientation. With regard to reasons for seeking therapy, most sought help for personal growth (71%), desire to improve as a therapist (65%), or adjustment or development issue (59%). Other reasons often endorsed included depression (38%), problem with spouse or significant other (32%), and a family issue such as substance abuse, divorce, or mental or physical illness (25%). Students who did not seek therapy either felt they had no need (56%) or could not afford it (53%); 8% were concerned about how it would be viewed by their training program.

Deutsch's 1985 study of 264 practicing therapists from various disciplines - primarily psychology and social work, but also counseling, education, and other related fields - obtained similar results: a large portion of her sample had sought therapy at least once – 47 % for relationship problems and 27% for depression. Of the 34% who had

considered seeking therapy but had decided against it, 11% were concerned about their confidentiality and about professional repercussions, 10% believed they should be able to work through their own problems, and 10% did not want to expend the effort necessary for therapy to be helpful; less than 1% found the cost too high. This latter percentage may be due to the fact that these were practicing professionals for whom therapy would be more financially feasible than for a graduate student.

In a study examining the use of personal psychotherapy by psychologists before and after entering clinical practice, Guy, Stark, and Poelstra (1988) found that therapists who had received therapy before entering professional practice were more likely to seek it out after receiving their degrees (r=0.17). Those who claimed a psychodynamic orientation were also most likely to have sought individual therapy both before (r=0.78) and after (r=0.14) graduation (p-values were not included). Those who conducted the most individual therapy after graduation obtained more individual therapy themselves (r=0.18). In this particular study, 18% of respondents never received any form of therapy (individual, couples, family or groups). A similar number (23%) had never received individual psychotherapy, which, as the authors point out, is the form regarded as most helpful in illuminating blind spots and resolving personal conflicts.

Pope and Tabachnick (1994) surveyed 476 psychologists to explore therapists' personal problems and their experience in therapy. The majority (84%) had been in therapy at some point in their lives, leaving 16% who had never experienced the role of client. These numbers correspond closely to those obtained by Guy et. al, 1988). The median number of therapists worked with was three and the median number of years spent in therapy was four. The average length of time passed since the last therapy

session was 15 years. Similar to the previous findings, those who identified as psychodynamic therapists were more likely to have been in therapy (94%). Following that were those who identified as eclectic (87%), then cognitive (71%). Furthermore, an apparent cohort effect was at work with regard to therapy status: 93% of those age 40 and under either had been or were currently in therapy, compared with 81% over age 50. With regard to issues addressed in therapy, some of the frequently endorsed problem areas were (in descending order): depression/general unhappiness, marriage/divorce, relationship (general), self-esteem and self-confidence, anxiety, career/work/studies, and family of origin. Clinical depression stood out as a large part of the therapists' lives in this study: 61% stated that, regardless of the problems addressed in therapy, they had experienced at least one episode of clinical depression. Four percent reported having been hospitalized in conjunction with their therapy. Eighty-six percent found therapy to have been very or exceptionally helpful. Some of the most important perceived benefits, as reported by the therapists in an open-ended question, were self-awareness/self-understanding, self-esteem/self-confidence, and improved skills as a therapist.

In their study of licensed psychologists employed either as academics (n=82) or practitioners (n=85), Wood, Klein, Cross, Lammers, and Elliott (1985) found that 39% of respondents were aware of colleagues whose work was being affected by drugs or alcohol and 40% knew of colleagues making sexual overtures towards clients. Additionally, 63% knew of colleagues experiencing depression or burnout. When asked about their own use of therapy in response to these difficulties, only 55% had sought help when experiencing any of the abovementioned problems. Nonetheless, the majority (68%) of respondents had been in personal therapy; 33.3% had sought therapy twice;

8.5% three or four times. Based on their respondents' assessments of the prevalence of problems among their colleagues as well as their own problem histories and use of therapy, the authors estimated 7%-14% of psychologists were experiencing a problem and were not seeking help.

Mahoney (1997) conducted a survey at a therapy conference of 155 master's (48%), doctorate (46%), and bachelor's (6%) degree psychotherapists. Eighty-eight percent reported having been in personal therapy at some point. Theoretical orientations included eclectic (54%), psychodynamic (19%), cognitive (15%), and behavioral (4%). Number of years of clinical practice ranged from 1 to 48 years (mean=13 years). Some of the most common responses to a question about personal problems experienced within the past year were episodes of irritability, emotional exhaustion, concerns about the size/severity of one's caseload, insufficient or unsatisfactory sleep, doubts about one's therapeutic effectiveness, problems in intimate relationships, chronic fatigue, and feelings of loneliness and isolation.

Guy and Liaboe (1986a) reviewed the literature for reasons therapy might not be sought out by its providers and found that both practical and personal factors prevented therapists from seeking help when it might be beneficial to do so. Fears of assuming a dependent role, embarrassment and shame related to identifying oneself as a patient, the reality of multiple relationships with potential treating therapists, fears of further therapy reflecting personal failure – or failure of the therapist provider, and previous unsuccessful therapies were all reported obstacles to seeking therapy. The authors speculated that some therapists may also secretly doubt the efficacy of therapy; may feel hesitation due to the often lengthy financial, emotional, and time commitment required when entering

therapy; may ascribe to the illusory norm that practicing therapists no longer require therapy; and may be unable to identify their own needs for therapy due to years of idealization by patients and possibly colleagues that have left them with a sense of superiority.

The Challenges of Clinical Practice

While conducting therapy often brings with it incredible rewards (Guy & Liaboe, 1986b; Kottler, 1993), there are also downsides to clinical practice. Therapists are prone to a variety of negative emotional sequelae from immersing themselves in the sorrowful worlds of others on a regular basis. The nature of clinical practice is such that, unless therapists actively attend to their emotional and mental health, it will take a toll on both.

Guy and Liaboe (1986b) reviewed several findings related to the emotional toll that the profession of psychotherapy seems to take on the interpersonal functioning of its practitioners. Psychotherapists were found to experience physical and psychic isolation, repeated feelings of abandonment and loss, and interpersonal distance from friends and family. Seemingly, the work of psychotherapy drained therapists' emotional reserves, and the depletion affected their ability to be empathic with their family members and friends. They also experienced significant problems with anxiety and depression that they attributed partly to their work as therapists. The authors speculate that providing individual therapy in particular can have a negative impact due to the physical and psychic isolation the therapist experiences. Therapists engage in intense, one-way relationships which focus only on the clients' needs. The fact that the goal of these

relationships is individuation and termination further subjects therapists to feelings of loss, loneliness and abandonment.

In another review, Farber (1983) found a variety of themes in therapists' dissatisfaction with their careers. Isolation was prominent, in terms of physical confinement, separation from colleagues, and social distance from the difficulty of explaining the nature of their work to friends and acquaintances. Lack of sufficient financial compensation as well as client appreciation for their efforts was another theme. Psychodynamically oriented therapists sometimes adopted a stance of emotional detachment that pervaded all of their interactions. These therapists were less emotionally invested in their own families, and related to them with "therapeutic distance" rather than the qualities of intimacy and mutuality that characterize healthy relationships. The same was found to be true of therapists' friendships. Family and friendship issues may come to seem trivial compared to the problems revealed in the office. Therapists who worked within agency settings complained of excessive workloads and organizational politics. The lack of feedback about their work after completion of training was also found to be a source of anxiety.

Norcross (2000) underscores the importance of recognizing the hazards of clinical practice. Psychotherapy often creates moderate depression and anxiety, as well as emotional exhaustion and distressed relationships. Therapists hesitate to name the residual effects of such emotionally draining work due, in part, to confidentiality considerations, isolation, and shame. Norcross describes the therapeutic benefits of acknowledging that one is not alone in the distress, and encourages therapists to avoid the trap of overpersonalizing their stress. He also encourages therapists to seek personal

therapy as part of a self-care regimen, and to self-monitor their own distress level; both of these strategies decrease the risk for professional burnout. It is often therapists experiencing burnout who become impaired. Therapists experiencing distress in their personal lives are much more likely to violate ethical standards and principles (Pope & Bouhoutsos, 1986).

Effects of Personal Therapy on Professional Functioning

Therapists who have been 'on the other side of the couch' often feel that their personal therapy is one of the most influential aspects of their development as therapists (Kaslow & Friedman, 1984; Skovholt and Ronnestad, 1995; Wiseman & Shefler, 2001). Personal therapy has been examined in terms of possible intrapersonal changes that impact how the therapist acts interpersonally in a professional context, in terms of client outcome, in terms of process variables, and in terms of therapists' attitudes about and use of personal therapy (Botermans, 1996, as cited in Wiseman and Shefler, 2001). This section will review the largely qualitative – and hence self-report - examinations of the impact that therapy has on therapists' professional lives.

Through a series of in-depth interviews with seven therapists, Macran, Stiles, and Smith (1999) found that therapists translated their experiences in personal therapy into ways of being as therapists themselves. Through insight into personal problems and through participating in therapy as client, they felt they were able to be more effective as therapists. Their reports revealed three main ways in which they believed personal therapy had impacted their functioning as therapists: (1) coming to understand how important their personal presence in therapy was and how to attend to and manage that

presence, (2) learning to manage their clients' need for space to work through their most difficult feelings, and (3) becoming able to work with their clients at a deeper, more meaningful level. Interviewees felt they became more able to be their real selves with their clients and better able to set and maintain boundaries. They reported enhanced awareness of topics and types of clients likely to 'prove difficult for them' and also learned to distinguish their feelings from their clients'. Their own experiences of the power of feelings and thoughts outside their awareness created a conviction in the reality of unconscious processes. They learned how to not misuse their power as therapists, and they became more empathic and accepting of their clients' intense and seemingly irrational feelings. They reported gaining a greater confidence in their clients' inner strengths and abilities to cope, and a greater capacity to tolerate clients' powerful feelings without wanting to 'make it better' for them. They also discovered that things clients said at the beginning and end of sessions were often highly clinically relevant.

A similar qualitative study by Wiseman and Shefler (2001) of five psychoanalytically oriented therapists who had all been in long-term personal therapy yielded six areas in which participants reported that personal therapy had impacted their personal and the professional development. These were as follows: (1) Past and current attitudes about the importance of personal therapy; (2) Impacts of personal therapy on professional identity; (3) Process impacts of personal therapy on one's being in the session; (4) Experiences as a patient in past and current personal therapy; (5) Experiences as a patient as self-in-relation to the personal therapist; and (6) Mutual and unique influences of didactic learning, supervision, and personal therapy. Most entered their first therapy for personal as well as professional reasons. They sought to work out their

personal problems, but also viewed therapy as central to their process of becoming a therapist. Those who underwent a required training analysis also saw it as meeting both personal and training goals. The respondents' professional identities were impacted in their acquiring a sense of professional self-confidence and their use of past or current therapists as professional models. They also acquired a conviction that personal therapy helped them improve their self-awareness, which was valued because of its perceived influence on their clinical work. Therapists felt that their experiences as clients helped them gain in empathic capacity and in the freedom to be authentic and spontaneous with their clients. Respondents who were currently in therapy described a great deal of overlap between their roles as clients and roles as therapists, in terms of shifting between these roles and the intricate interconnections and dialogue that took place between those two experiences. Therapists experienced their analysts as parent figures, and saw them not only as someone to imitate but also as someone from whom they could individuate and forge their own way as therapists. Components of their professional identity were seen as essential and as interacting, especially personal therapy and supervision. The experience of being a supervisee was brought into personal therapy, and personal therapy facilitated a deeper and more meaningful experience in supervision in terms of integrating, when clinically relevant, personal issues into supervision; supervision also facilitated one's understanding of the professional impact of personal therapy. While supervision was seen as a relevant component, personal therapy was often viewed as the single most important influence on development as a therapist, and relatedly, experiential knowledge and self-awareness were seen as necessary to fully understand the psychotherapeutic process.

Interviews conducted by Kaslow and Friedman (1984) with clinical psychology doctoral students revealed that the trainees perceived their personal therapy had several positive impacts on their clinical work. These included an increased respect for the struggles of their clients, an increased ability to simply "be with" as opposed to "do for" their clients, an enhanced ability to differentiate their own feelings from their clients,' and greater ability to attend to undesirable countertransference reactions. Additionally, advanced students experienced countertransference-based supervision as less intrusive and more helpful than did students who were less advanced.

Norcross, Strausser-Kirkland, and Missar (1988) observed several commonalities in the literature of how personal therapy may benefit therapists' clinical work. They summarized these as follows: personal therapy improved the emotional and mental functioning of the therapist, provided the therapist with a greater understanding of personal dynamics and conflicts thereby enabling clearer perceptions and reduced countertransference, alleviated emotional stresses resulting from the draining impact of clinical work, socialized the therapist to the profession and facilitated the process of internalizing the therapist role, increased therapists' understanding of and respect for their clients' needs, and provided a model for the use of techniques and interpersonal skills. These same authors also surveyed psychologists (n=234), psychiatrists (n=104), and clinical social workers (n=171) to examine aspects of psychotherapists' personal therapy experiences. While this was primarily a quantitative study, the authors also included an open-ended question for participants' self-report. Respondents were asked about the number of times they had sought therapy, their age at the time, the length of the therapy, the theoretical orientation of their therapist(s), the frequency and duration of sessions, the

modality of therapy, and the outcome of therapy as they perceived it on dimensions of behavior/symptomatology, cognitions/insight, and emotions/relief. They found that insight-oriented therapists were more likely to have had therapy (88% of psychoanalytic and 82% of psychodynamic therapists sought therapy of their own initiative). Following these were therapists identifying as systems (85%), cognitive (69%), Rogerian/person-centered (67%), eclectic (62%), and behaviorist (47%). With regard to number of treatment experiences, 32% reported one, 32% reported two, 22% reported three, and 14% reported four or more. Fifty-five percent sought therapy primarily for personal reasons, 10% primarily for training purposes, and 35% for personal and professional growth. The three most common reasons for seeking therapy were marital conflict (20%), depression (13%), and anxiety (12%). Other presenting reasons included interpersonal difficulties, family-of-origin concerns, need for self-understanding, training needs, and career concerns. The primary treatment modality was individual therapy (80% of sample) conducted in an independent practice setting. The average number of therapy hours received was 224 (SD=288), with psychoanalytic therapists having received the longest treatment, and behavioral therapists the shortest. With regard to treatment outcomes, the vast majority of respondents indicated significant or moderate improvement in terms of behavior/symptomatology (92%), cognitions/insight (93%), and emotions/relief (93%). The open-ended question asked respondents to describe any lasting lessons concerning the practice of therapy from their own treatment experiences. The most frequent responses centered around the importance of the personal relationship, warmth, and empathy (12%), the importance of transference and countertransference (8%), and the need for patience and tolerance (7%). Four percent also described the

importance of unconscious motivations and material, something obviously relevant to the concept of transference and countertransference.

Buckley, Karasu, and Charles (1981) surveyed 71 psychotherapists in a quantitative study about their experiences in personal therapy. Seventy-six percent had completed psychoanalysis and 24% had participated in psychotherapy. Length of time since the last session varied from 1 to 18 years, with 30% having terminated in the past 1 to 4 years, 38% in the past 5 to 10 years, and 32% in the past 11 to18 years. Respondents indicated improvement in several areas related to the effectiveness of psychotherapy: self-esteem (94%), work function (86%), and character change (89%). Based on ratings of particular therapist qualities, the specific factors of "interpretation" and "insight" were positively correlated with positive character change and the alleviation of symptoms. These ratings remained constant regardless of length of time since termination.

Garfield and Bergin (1971) conducted a study of 18 advanced graduate students in a psychotherapy practicum and found that those who participated in personal therapy – in their case, analysis – while in training obtained the worst client outcomes. Furthermore, the longer the personal therapy experiences, the worse the client outcome. Client outcome was measured by changes in the Depression scale and in the K Correction scale of the MMPI and changes on a 5-point rating of disturbance completed by therapist-trainees at the beginning and end of treatment. Because of the surprising nature of the results, the researchers asked the therapist-trainees to complete an MMPI themselves; 10 agreed to do so. A similar trend to that obtained from the earlier part of the study emerged: therapists with a higher level of disturbance based on their MMPI scores had worse client outcomes. When they looked at certain scales on the MMPI, which all

participants had completed, they found no differences across therapists in the amount of therapy received by the more and less disturbed therapists as assessed by the MMPI. However, no tests of significance were conducted in this study because of the small sample size. They noted the possibility that the more disturbed therapists sought and obtained longer therapy experiences and that the finding of longer therapy experiences correlating to worse outcomes could be a spurious one, with the worse outcomes actually stemming from the higher pathology in this group. When they compared the amount of therapy with therapist level of pathology as measured by the MMPI, however, they found no difference in the amount of personal therapy sought by the more and the less disturbed therapists.

It has been suggested that personal therapy would help trainees manage the countertransference that clinical training would inevitably elicit, and, consequently, enhance their therapeutic effectiveness (Szurek and Berlin, 1966, as cited in Kaslow, 1984). This notion was supported in another study using the MMPI to assess therapist distress. Peebles (1980) studied the ability to demonstrate empathy, warmth and genuineness in session along with the experience of personal therapy for 17 advanced clinical psychology doctoral students enrolled in psychotherapy practica. The trainees completed the MMPI and were rated using the Truax and Carkhuff Scales of Accurate Empathy, Nonpossessive Warmth, and Genuineness. She found no significant differences between therapists-in-training currently in therapy and those not in therapy in their abilities to display empathy, warmth, and genuineness, in spite of the fact that those in therapy were indeed reporting greater subjective distress as measured on the MMPI. Peebles was able to demonstrate a positive relationship between numbers of hours of

personal therapy and an ability to be empathically accurate and engage genuinely in session.

In an attempt to determine whether therapists who have undergone personal therapy were more effective than those who had not received therapy, Clark (1986) reviewed the empirical literature – a total of seven studies - concerning the usefulness of therapy and the effects on client outcome; he limited his review to those studies that controlled for the experience of the clinician. He concluded that, based on the studies he had reviewed, personal therapy for the therapist could not be shown to be beneficial to client outcome; the experience of the therapist, however, appeared to have some relationship to client outcome. He noted that the studies reviewed failed to consider either the motivation for the clinician to have sought therapy or the point in the clinician's career that therapy occurred. Notably missing from the reviews were descriptions of how variables such as "patient improvement" or "patient's final status" were defined and assessed. Also absent from the reviews was role of therapists' level of disturbance and whether it was controlled for. Finally, Clark did not review any studies in which it was assumed that personal therapy would positively impact client outcome by reducing countertransference, because he chose to focus on the broader issue of whether an effect of personal therapy on client outcome even existed.

The Countertransference Connection

The collection of internal and interpersonal experiences and responses, otherwise generally known as countertransference, is often thought to be an invaluable source of information about the client and how she/he interacts with others (Gelso & Hayes, 1998;

Gorkin, 1987). When outside one's awareness, however, it can be detrimental. Lack of awareness of personal issues and 'blind spots' can result in a host of reactions – both internal and behavioral – that adversely impact the therapist-client relationship, as well as the likelihood that the client will benefit from therapy. Therapists might be blocked in their empathic ability, might filter out relevant client material that is too painful to hear, or might inadvertently minimize clients' struggles in an attempt to avoid their own pain. Because little literature exists on countertransference *awareness* and its centrality within the therapy context, most of the following discussion will be on other aspects of countertransference, such as countertransference management.

A few researchers have attempted to classify aspects of countertransference in an attempt to increase understanding of this very complex construct. Geddes and Pajic (1990) developed a taxonomy of countertransference reactions which identified seven types of responses: classic, complementary, concordant, indirect, institutional, stylistic, and ecological. *Classic Countertransference* refers to the unconscious conflicts and the past conditioning of the therapists that interfere with treatment. It is typically expressed in some form of love (fondness, concern) or hate (mistrust, resentment). *Complimentary Identification* is the process by which the client induces in the therapist the feelings, thoughts, and behaviors of an earlier relationship pattern. This occurs most frequently with clients diagnosed with borderline personality disorder and is also termed projective identification. *Concordant Identification* entails an empathic identification with the client to the extent that, as in complimentary identification, the therapist may attempt to recreate for her/himself the client's emotional state or history. The difference between the two lies in the type of information that each reveals about the client: one is about

early interpersonal relationships, the other about the client's current experience of self. *Indirect Countertransference* occurs when a third party whose opinion is important to the therapist impacts the therapist's feelings toward the client. The client becomes the means for the therapist to obtain acceptance from a real or imagined source, typically a supervisor, colleague, or referral source. *Institutional Countertransference* for the therapist occurs when the client forms a stable and idealized attachment to the institution in which the therapist is employed, rather than to the therapist. This is most commonly found in clients who have frequently been transferred among therapists and long for a sense of permanence. *Stylistic Countertransference* is the extent to which the therapist's personality traits and self-presentation influence the therapy. Style of dress, office décor, and other physical indicators of personal style are also included in this category. *Ecological Countertransference* refers specifically to the impact of daily and episodic events in the life of the therapist on the therapy. It is to be distinguished from Classic Countertransference by the transient nature of the sources of distortion in treatment. This type may occur when therapists are experiencing a painful life event, such as marital conflict.

Hayes (1995) took a more general approach to his development of a framework for better understanding and researching countertransference. He categorized the phenomenon into five components that are meant to characterize any countertransference phenomenon rooted in the therapist's personal history: origins, triggers, manifestations, effects, and management. Origins are the areas of intrapersonal unresolved conflict within the therapist. Triggers are the actual events within therapy that touch upon or elicit these unresolved issues. Manifestations are the therapist's affective, cognitive, and

behavioral reactions. Effects are the results of countertransference manifestations on the quality of the therapy process and outcome. Finally, management refers to the therapist's strategies for handling countertransference.

Gelso and Hayes (2001) reviewed the literature on countertransference effects on treatment outcome and countertransference management conducted since 1977. Though the body of literature on this area is growing, it is noteworthy that they found only ten studies addressing the issue of effects of countertransference on outcome, and a similar number addressing management of countertransference. Not surprisingly, the studies of effects supported the notion that countertransference that is unmanaged adversely affects treatment outcomes. The qualitative investigations, in particular, revealed that both experienced and inexperienced therapists exhibit countertransference often, and that unmanaged countertransference can result in the premature ending of therapy. In contrast, countertransference that was competently managed was found to positively affect therapy outcomes. A number of studies investigated factors originally observed by Reich (1951, as cited in Gelso & Hayes, 2001) as essential to countertransference management: therapist empathy in the form of partial identification with the client, awareness of countertransference feelings, and the ability to make sense of these feelings. Overall, high empathic ability, openness to countertransference feelings, and adherence to a theoretical framework were all found to facilitate countertransference management.

Peabody and Gelso (1982) examined the interrelationship between countertransference management, empathy, and openness to countertransference feelings. Because both the process of countertransference and empathy involve an identification with the client, they theorized that a high degree of empathy would co-occur with a

sensitivity to one's own feelings, a sensitivity seen as necessary to effectively manage internal reactions without acting them out. Their sample consisted of 22 doctoral students whose empathic abilities were rated by undergraduate volunteers who had been counseled for 1 hour. To assess openness to countertransference feelings, the authors administered a survey immediately afterwards which asked trainees to rate statements in terms of their appropriateness in therapy; several items reflected countertransference feelings. Trainees also listened to audiotapes of hostile, seductive, and neutral clients and were instructed to select one of two interpretive responses they might make at various stopping points in the tapes. They found that countertransference behavior (defined as withdrawal of personal involvement by the trainee) was significantly and negatively related to empathic ability as hypothesized, though only with seductive clients. They also found that openness to countertransference feelings was significantly and positively related to empathic ability. Openness to countertransference feelings was negatively related to countertransference behavior for all three client types, though these relationships did not attain statistical significance. The results suggest that therapists who have greater awareness of conflictual countertransference feelings are more empathic and possibly less likely to act out these feelings.

Robbins and Jovkovski (1987) sought to understand whether therapists who were both more aware of their countertransference feelings and who held to a theoretical framework for understanding those feelings would engage in less countertransference behavior. Their sample consisted of 58 doctoral graduate students. Each person made verbal responses at predetermined stopping points to audiotapes of an actress portraying either a seductive/sexual or a neutral (with respect to sexuality) client. Surveys were

administered to assess awareness of countertransference feelings and level of theoretical framework employed. As with the previous study, countertransference behavior was measured through an index of withdrawal of involvement with the client. An interaction effect of theoretical framework and awareness of countertransference feelings on withdrawal of involvement was found. Participants with a high level of theoretical framework exhibited the highest withdrawal at low levels of awareness, and the lowest levels of withdrawal at moderate and high levels of awareness. A main effect of awareness of feelings on withdrawal of involvement was also found. Taken together, the results suggest that the use of a theory decreases emotional involvement with a client when there is low awareness of countertransference feelings, but increases engagement when there is moderate or high level of awareness. This study was later replicated by Latts and Gelso (1995).

MacDevitt (1987) surveyed 185 practicing clinicians (97% had doctoral degrees) about their personal therapy histories and about their reactions to 25 hypothetical psychotherapy situations. The latter constituted a survey designed to measure countertransference awareness (CA). The instrument, the Therapy Vignette Questionnaire (TVQ), was created by MacDevitt and consisted of 25 items. Each item was a vignette about a psychotherapy situation and included five multiple-choice options, one of which measured the participants' preference for introspection. The other choices measured preference for taking some concrete action, sharing feelings or thoughts with the client, rationalizing one's reaction, and blaming the client. Therapists were instructed to choose the option that best described how they would react in the situation described by each item. Item examples included:

1) A fourteen year old boy must come to you to avoid reform school. During his first session, he spits in your face and spouts obscenities at you. You are enraged, and almost to the point of losing control of yourself.

A. Your reaction is completely understandable.

B. His behavior is clearly unacceptable.

C. Associate to and examine your reaction to increase your understanding.

D. Express your feelings to him.

E. Set a limit on this behavior.

2) When you see Mrs. L., you usually find yourself going over the fifty minutes allotted her.

A. Mrs. L. may manipulate you into giving her extra attention.

B. Something is probably transpiring in your relationship with Mrs. L. It would be a good idea to increase your awareness of her impact on you.

C. As long as this does not inconvenience another client, it is harmless.

D. Discuss this observation with your client, and see if the two of you can understand the phenomenon.

E. Pay more attention to the time in future sessions.

In Example 1, the countertransference awareness option is C; in Example 2, it is B. The countertransference awareness (CA) score is calculated by a frequency count of the selection of the countertransference awareness option. In this study, 46% described their theoretical orientation as eclectic, 20% as psychoanalytic, 8% as cognitive, and 7% humanistic. Eighty percent of respondents reported having had therapy. Of those, 48% described their most helpful therapist as psychoanalytic, 16% as eclectic, 14% as

humanistic, and 9% as gestalt. The mean number of therapy hours received was 409. A significant positive relationship was found between CA and number of hours of therapy received ($r=0.32$, $p<0.0005$). Significant positive relationships were also found between CA and claiming a psychoanalytic orientation ($r=0.41$, $p<0.0005$) and describing one's most helpful therapist as psychoanalytic ($r=0.26$, $p<0.0005$). Further analysis revealed that number of sessions of personal therapy received and claiming a psychoanalytic orientation each made an independent contribution to CA. The author concluded that these findings lent support to the notion that personal therapy leads to greater professionally relevant self-awareness (CA).

A long-time researcher in the area of countertransference, Hayes and his colleagues (Hayes, Gelso, VanWagoner, and Diemer, 1991) formulated a theoretical statement of countertransference management. They theorized that management of countertransference was comprised of five factors: therapist insight, self-integration, anxiety management, empathy, and conceptualizing. Therapists should possess awareness of their own feelings, a basically healthy character structure as defined by recognition of ego boundaries or the ability to psychologically differentiate themselves from others, and the ability to experience but also understand and control anxiety. They should be able to partially identity with clients and therefore focus on clients' needs through engaging in empathy, and they should possess the ability to use theory to inform the therapeutic relationship and their understanding of clients' dynamics. Hayes et. al. also suggested that empathy may be related to sensitivity to one's own feelings, including countertransference feelings. The five factors were later incorporated into the Countertransference Factors Inventory (CFI; Van Wagoner, Gelso, Hayes, & Diemer,

1991), a measure designed to assess therapists on each dimension; each factor constitutes a subscale on the instrument.

The first use of the original CFI was to assess differences between reportedly ‘excellent’ and ‘average’ therapists in ability to manage countertransference reactions. The authors asked 122 counselors to imagine a counselor in general or a counselor whom they considered to be excellent. They were then asked to rate this person on the five dimensions of the CFI. At the time, the instrument contained 50 items. Counselors who were considered ‘excellent’ received significantly higher ratings on all five subscales. The five subscales were also found to possess high internal consistency (Cronbach alpha ranges from 0.88 to 0.97; Minadeo, 1993, as cited in Gelso, Fassiger, Gomez, & Latts, 1995; Van Wagoner, Gelso, Hayes, & Diemer, 1991).

In another study of the original CFI (Hayes, Gelso, Van Wagoner, & Diemer, 1991), the authors recruited 33 psychologists judged to be experts in the area of countertransference and asked them to rate every item on the CFI on its importance in the management of countertransference. The mean-item scores for each subscale ranged from 3.4 to 4.3, on a scale of 1 (not important) to 5 (very important). The subscales of self-insight and self-integration both received mean scores of 4.3, anxiety management received 3.7, empathy received 3.6, and conceptual skills received 3.4.

In 1995, Gelso, Fassinger, Gomez, and Latts developed the short version of the CFI, Form-D. Because certain items appeared to be direct elements of, as opposed to correlates of, countertransference management (Minadeo, 1993), they used only those items judged to directly assess how the therapists reacts during therapy. These items have been found to have high internal consistency (Gomez, Gelso, Fassinger, & Latts,

1995; Minadeo, 1993). To ensure high content validity, they used only those items that experts in the study by Hayes, Gelso, Van Wagoner, and Diemer (1991) rated at 3.5 or above. Coefficient alphas for this final modified version of the CFI were as follows: total score (21 items) = 0.93, self-insight (5 items) = 0.71, self-integration (4 items) = 0.76, empathic ability (6 items) = 0.80, anxiety management (2 items) = 0.92, and conceptualizing ability (4 items) = 0.88.

Using the same 21-item modified version of the CFI Form-D in an investigation of the relationship between therapist countertransference management ability and therapy outcome, Gelso, Latts, Gomez, and Fassinger (2002) found that countertransference management correlated positively with client outcome. The better the therapist-trainees' abilities to manage their countertransference, the more their clients improved at the end of the brief therapy experience. The total CFI score was significantly positively correlated with ratings of client outcome ($r=0.36$, $p<0.05$), as measured by the Counseling Outcome Measure (COM). Self-integration ($r=0.40$, $p<0.05$), anxiety management ($r=0.36$, $p<0.05$), and conceptualizing skills ($r=0.51$, $p<0.01$) were also significantly correlated with client outcome. The results of this study suggest that countertransference management is indeed related to client change. While correlations for self-insight and empathy did not emerge as significant in this particular study, it is important to note that all subscale correlations were relatively close in size, and that one cannot conclude some components to be more important than others in the management of countertransference as measured by the CFI.

Hayes and Gelso (1993) examined the relationship between countertransference and the affective, behavioral, and cognitive reactions to issues likely to trigger

countertransference; in this case, these triggers were sexual orientation and HIV status. Participants were licensed practicing psychologists (n=4) and doctoral students (n=30). They completed questionnaires assessing their level of homophobia and death anxiety, and then watched a videotaped client whom, depending on the experimental condition, they were made to believe was either gay or heterosexual and HIV-positive or HIV-negative. They were instructed to respond verbally into a microphone at pre-determined pauses, as if they were interacting with the client. Following this, they completed a measure of state anxiety and a cognitive recall task. The affective aspect of interest, anxiety, was measured using the state anxiety measure; the cognitive aspect, defined as inaccuracy in recalling client material, was measured using the cognitive recall task; and, the behavioral aspect was measured by analyzing participants' verbal responses in terms of approach or avoidance behaviors. They found that participants who endorsed high levels of homophobic attitudes were found to engage in greater verbal avoidance behavior with videotaped gay clients. HIV status was found to impact counselor discomfort on an affective level: participants who believed they had watched an HIV-positive client experienced higher levels of state anxiety than those who believed they had watched an HIV-negative client. The authors concluded that homophobia appeared to be a source of countertransference behavior for male therapists working with male clients. While these results were specific to homophobia and death anxiety, they suggest that, once triggered, countertransference can be manifested behaviorally in session.

Using an approach similar to that employed by Hayes and Gelso (1993), Gelso, Fassinger, Gomez, and Latts (1995) sought to operationalize countertransference in terms of affective, cognitive, and behavioral components. Specifically, they investigated the

role of gender, homophobia, and countertransference management in countertransference reactions. Sixty-eight students in masters and doctoral training programs were randomly assigned on the basis of gender to watch a videotape of a female client who presented with sexual problems and who, depending on the experimental condition, was characterized as either lesbian or heterosexual. Participants completed a measure of homophobia prior to watching the videotaped client. Consistent with the design of Hayes and Gelso (1993), participants were asked to make verbal responses at several pre-determined stopping points in the videotape. The trainees' state anxiety was the affective component of countertransference and was assessed using a state anxiety measure immediately following the interaction with the client. The ratio of avoidance to the sum of approach and avoidance verbal behaviors was the behavioral measure of countertransference. The cognitive component was measured by the proportion of sexual words participants recalled after interacting with the client. The researchers were also interested in the trainees' ability to manage their countertransference and obtained completed CFIs (Form-D) from supervisors who had supervised the trainees within the past year. As hypothesized, female trainees were less accurate than their male counterparts in recall of sexual words used by the lesbian client; this was not the case for the heterosexual client. They also found trainees' homophobia to be directly related with verbal avoidance behaviors to the lesbian client. With regard to countertransference management, those who were rated on the CFI as having greater anxiety management and self-integration skills had less anxiety when interacting with the lesbian client. As was the case with the Hayes and Gelso (1993) study, this study produced further evidence that

countertransference management was related to therapists' in-session behavior with their clients.

The only study found to directly assess the relationship of countertransference management to therapy outcome (Gelso & Hayes, 2001) was conducted by Gelso, Latts, Gomez, and Fassinger (2002). The authors had 32 graduate-student therapists and their supervisors rate outcomes of one therapy case (per dyad). Therapist-trainees completed a measure of client disturbance after the first session and a measure of client outcome after termination. Supervisors completed the same measure of client outcome as well as a measure of their supervisees' countertransference management (CFI; Van Wagoner, Gelso, Hayes, & Diemer, 1991). The outcome ratings obtained by both supervisors and trainees correlated positively to the CFI scores overall and on three of five subscales (Self-Integration, Anxiety Management, and Conceptualizing Skills). This study provided support for Gelso and Hayes' (2001) findings that countertransference management was related to client outcome, and if managed well, it could positively affect therapy outcomes.

Two studies attempted the use of the CFI using self-ratings, but neither found this to be an effective way of measuring countertransference phenomena. Hayes, Riker, and Ingram (1997) investigated the relationship between countertransference behavior and the CFI-R, a revised version of the original CFI, which included items from the self-insight, self-integration, anxiety management, and empathy scales. Counselor-trainees' former supervisors rated their work using the CFI-R, and the trainees completed the CFI-R as a self-report measure. Because the CFI-R was not originally intended for self-report use, the authors changed pronouns on the inventory from "she/he" to "I." Counselor-trainees'

self-report scores on the CFI-R did not emerge as related to any of the measures of countertransference used in the study, including former supervisors' CFI-R ratings of their countertransference behavior and trainees' countertransference verbalizations in session. Rosenberger and Hayes (2002) completed a case study in which they analyzed countertransference in a therapy dyad for 13 sessions. The therapist completed the CFI-R after each session along with several other instruments. While the researchers did find some evidence suggesting that the self-report nature of the CFI-R scores did not impact the validity of the use of the instrument in such a manner, they cautioned that the very nature of the research (case study) as well as several methodological/instrument limitations (such as determining which unresolved conflicts are centrally relevant for a given person) made it difficult to state with confidence that their results reflected a true measure of the phenomenon.

Summary

Although we might prefer to believe otherwise, many therapists have significant personal problems and dysfunctional families-of-origin (Deutsch, 1985; Guy, 1987; Pope & Tabachnick, 1994; Racusin, Abramowitz, & Winter, 1981). The toll of clinical work also leaves therapists vulnerable to problems and increased countertransference (Farber, 1983; Guy & Liaboe, 1986b). This points to a need for personal therapy for practitioners, as therapists' mental health and clear perceptions are essential to their clients' welfare and progress. Though therapy is known to bring about positive changes in clients' lives (Lipsey & Wilson, 1993; Seligman, 1995; Smith, Glass, & Miller, 1980), and many therapists feel that personal therapy is one of the most significant parts of their

professional development (Kaslow & Friedman, 1984; Macran, Stiles, & Smith, 1999; Wiseman & Shefler, 2001) not all therapists seek therapy (Pope & Tabachnick, 1994; Wood, Klein, Cross, Lammers, & Elliott, 1985). This is noteworthy because personal therapy has been found to correlate positively with countertransference awareness: the longer the therapy experience, the greater the countertransference awareness (MacDevitt, 1987). This is echoed in the voices of those practitioners who *have* sought therapy: many report an increased self-awareness along with an appreciation of the need to attend to countertransference and transference processes (Macran, Stiles, & Smith, 1999; Wiseman & Shefler, 2001). This is significant, as countertransference awareness has been found to be an important component of the ability to manage countertransference (Hayes, Gelso, VanWagoner, and Diemer, 1991; Peabody & Gelso, 1982; Van Wagoner, Gelso, Hayes, & Diemer, 1991).

This study was intended to contribute to the literature on countertransference management, broadly, and countertransference awareness, specifically, as well as that on personal therapy. We know that countertransference awareness is necessary for countertransference management, and we know that personal therapy is effective and important for therapists' optimal functioning both as people and professionals. What is missing is an understanding of the connection between personal therapy and professional self-awareness. Therapists themselves report increased countertransference awareness as a result of personal therapy, but this finding has emerged from several qualitative, self-report studies, none of which were looking specifically at countertransference awareness. Only one study (MacDevitt, 1987) has empirically examined the relationship between personal therapy and countertransference awareness. This study, however, used an

experimenter-designed questionnaire completed by participants; it also involved practicing therapists. To my knowledge, my study was the first to empirically investigate the relationship between personal therapy and countertransference awareness using ratings by others. It was also the first to do so using the Countertransference Factors Inventory. It was hoped that this study would underscore the importance of personal therapy for therapists, the value of countertransference awareness, and the importance of one for the other.

Chapter III

METHOD

Instruments

Countertransference Factors Inventory

Supervisors were asked to rate aspects of their supervisees' countertransference by completing the Countertransference Factors Inventory (CFI) Form-D (see Appendix A). The CFI Form-D is a 21-item measure of countertransference management. It is distinguished from the longer 40-item version, Form-T, by its exclusive focus on items measuring aspects of countertransference that have direct relevance in the psychotherapy process. The shorter form was deemed to be more appropriate for this study, as the longer form includes items that require supervisors to have knowledge of supervisees' general internal processes. For example, the item asking if the therapist, "understands the background factors in his/her life that have shaped his/her personality," which appears on Form-T but not on Form-D, requires knowledge about a supervisee's internal awareness that may or may not become known in supervision (Gelso, personal communication, 2003; Gelso, Fassinger, Gomez, & Latts, 1995). Supervisors rated their supervisees on each item on a 5-point Likert scale (1=strongly agree, 5=strongly disagree); higher scores indicated higher levels of countertransference management. The ratings were based on global assessment of countertransference management, as opposed to evaluation of

specific sessions or clients. The CFI has 5 subscales, reflecting five characteristics thought to comprise the management of countertransference feelings: self-insight, self-integration, anxiety management, empathy, and conceptual skills. The number of items comprising each subscale varied from 2 to 6. Examples of items and their corresponding subscales follow.

The therapist:

- is often aware of feelings in him/her elicited by clients (self-insight)
- often uses his/her past experiences to aid in understanding the client (self-integration)
- feels confident working with most clients (anxiety management)
- at the appropriate times, stands back from a client's emotional experience and tries to understand what is going on with the client (empathy)
- is usually able to conceptualize client dynamics or issues clearly (conceptual skills)

Personal Therapy Survey

Supervisees were asked to complete a brief experimenter-designed survey about their history and experience of personal therapy, entitled the Personal Therapy Survey. Questions on the survey inquired about the respondents' theoretical orientation and that of their therapist, practical details about their therapy (such as number of sessions), and reason for seeking therapy. An open-ended question at the end of the survey allowed respondents to share their perception of how their personal therapy had impacted them as therapists.

Participants

Participants were clinical supervisors at APA-accredited internship sites meeting the abovementioned criteria who were currently supervising the work of one or more interns, postdocs, or ABDs, and supervisees who were at the doctoral psychology intern level or above (postdocs or ABDs). As supervisors in this study were only asked to rate their supervisees, no demographic information was collected for this group, including theoretical orientation. Demographic information (for supervisees) is described below.

Supervisors

Supervisors provided clinical supervision to interns, post-doctoral interns, or ABD clinicians at APA-accredited internship sites in the United States.

Supervisees

Supervisees varied in age from 25 to 55, with a mean age of 31.35 (SD=6.56) and a median age of 29. The mean and median age of those who had sought therapy since beginning their graduate training was 32.60 (SD=7.40) and 30, respectively; the mean and median age of those who had not sought therapy after beginning their graduate training was 28.41 (SD=1.97) and 28, respectively. When the five most extreme values were removed from the calculation for those who had sought therapy after beginning their graduate training, the mean age was 30.29 (SD=4.03), and the median was 29. Forty-three were female (75%); 14 were male (25%). The largest ethnic group represented was European-American (44 respondents), which constituted 77% of the sample. The remaining 23% percent of the sample was split between 4 Asian participants (7%), 4 Hispanic/Latino/a participants (7%), 2 Jewish participants (4%), 1 American-

Indian participant (2%), and 1 multiethnic participant (2%). One respondent did not list an ethnic affiliation.

Theoretical Orientation

Supervisees frequently listed more than one theoretical orientation, so responses were grouped into primary and secondary orientation. The first one listed was deemed the primary orientation.

Seventeen supervisees described their primary theoretical orientation as cognitive-behavioral (30%), which was the most frequently reported approach. Following this were 8 respondents who identified as psychodynamic (14%), 7 as integrative (12%), and 6 as interpersonal (11%). The remainder consisted of 4 who identified as cognitive (7%), 3 as behavioral (5%), 3 as eclectic (5%), 3 as family systems (5%), 3 as humanistic (5%), 2 as existential (4%), and one as developmental (2%).

Forty-four percent (25) of the supervisees listed two theoretical affiliations. Of these, 5 identified their secondary orientation as cognitive-behavioral (20%), 4 family systems (16%), 4 psychodynamic (16%), 3 interpersonal (12%), 3 humanistic (12%), 2 eclectic (8%), 2 behavioral (8%), one existential (4%) and one feminist (4%).

Respondents' Therapists' Theoretical Orientation

Forty supervisees (70%) had had therapy after beginning their graduate training. Thirteen described their therapists' theoretical orientation as psychodynamic (23%), 8 as cognitive-behavioral (14%), 5 as interpersonal (9%), 3 as family systems (5%), 3 as humanistic (5%), 2 as eclectic (4%), 2 as existential (4%), 2 as feminist (4%), 1 as gestalt (2%), and 1 as integrative (2%).

Twelve supervisees (30%) listed more than one theoretical orientation for their therapist. Secondary orientations were distributed as follows: 3 listed psychodynamic (5%), 3 humanistic (5%), 2 interpersonal (4%), 2 feminist (4%), 1 existential (2%), and 1 family systems (2%).

Aspects of Therapy After Beginning Graduate Training

For the purposes of this study, only therapy experiences that occurred after supervisees had begun graduate training were of interest. The directions on the Personal Therapy Survey asked supervisees to answer the questions with regard only to the most impactful therapy experience they had *after* beginning their graduate clinical training. Respondents were asked to check which option best described the primary reason they sought therapy. The majority of supervisees (33) endorsed "For Personal Reasons" as the main reason they sought therapy (83%). Six endorsed "To Become a Better Therapist" (15%) and 1 person checked "It Was Required By My Program" (3%).

Length of therapy was obtained from two questions on the Personal Therapy Survey: how long was the therapy experience, and what was the frequency of sessions (i.e., weekly, biweekly). The length was then calculated in terms of one session counting as one week. It varied from 2 sessions to 416. The mean was 95 sessions (SD= 112) and the median was 52 sessions.

Time passed since the therapy ended (also calculated in weeks) varied from 0 (therapy was ongoing) to 1,560 weeks. The mean was 137 weeks (SD= 267) and the median was 65 weeks.

Procedure

Training directors at APA-accredited clinical and counseling psychology internship sites were initially contacted by e-mail by the researcher to obtain names of staff who were currently supervising clinicians at the doctoral intern level and beyond. Only sites for which clinical work was a significant component of the internship were selected; these sites were identified by their stated preference for counseling and clinical psychology program candidates on the Association of Psychology Postdoctoral and Internship Centers (APPIC) website. Sites specifically seeking school psychology candidates were not contacted. With that exclusion, attempts were made to contact every training director listed on the APPIC website. When an e-mail address for a training director could not be obtained, the e-mail for training directors was sent to the contact person designated by APPIC for internship applicants, with a request to forward the e-mail to the training director. The initial e-mail (see Appendix B) consisted of a description of the study and a request to provide the researcher with contact information (name and e-mail address) of appropriate staff - supervisors who were currently supervising the clinical work of an intern, postdoctoral intern (postdoc), or an 'All But Dissertation' clinician (ABD) - for purposes of recruiting participants. Training directors were asked to either provide a list of current clinical supervisor contact information (name and e-mail address) or forward another e-mail (see Appendix B) describing the study in greater detail and inviting current clinical supervisors to participate. Some training directors chose to simply forward the initial e-mail (for training directors) to appropriate staff. Regardless of how they learned of the study, clinical supervisors who were interested in participating were asked to e-mail the researcher. If they had not seen

the e-mail intended for supervisors, it was sent to them at that point. Those who decided to participate were asked to give their address to the researcher and were then sent the study materials. The materials included the CFI Form-D (see Appendix A) as well as the Personal Therapy Survey (see Appendix A). Supervisors were sent one set of materials for each person they supervised. Supervisors were asked to complete the CFI rating the supervisee's countertransference management, and to give the Personal Therapy Survey to that supervisee for completion. Each person in the pair had a separate envelope for returning the forms directly to the researcher. All data was anonymous. Personal Therapy Surveys and CFIs were coded to match (but not coded to identify participants) so that the surveys would be paired correctly upon receipt. A follow-up e-mail reminding participants to return their surveys was sent to every supervisor who had been sent surveys.

Because the study required multiple levels of contact, response rates are grouped accordingly into training directors and clinical supervisors (below). The actual (final) sample and associated characteristics follow.

Training Directors

Of 428 potential sites, 405 sites (95%) were successfully contacted. Only those who could be reached by e-mail were contacted. Therefore, 13 sites (3%) were excluded due to failure of the e-mail to be delivered, and 10 sites (2%) due to having no e-mail address listed. Of the 405 sites that were contacted, 172 training directors responded to the e-mail announcing the study. 153 training directors (38%) either replied with, or directed the researcher to, a list of supervisor contact information, or agreed to forward the initial e-mail or second e-mail for supervisors to appropriate clinical supervisors. In

some cases the response was implicit, as the researcher did not receive a reply from the training director, but did receive e-mails from supervisors at the particular site who had read the initial e-mail. Four training directors (2%) initially responded to the e-mail, seeking clarification about the study, but then did not follow-up after the researcher replied. Another 5 sites (3% of those who responded) were unable to participate due to varying circumstances, including a lengthy IRB process that extended past the data collection period, having no interns or postdocs this year, researcher missing the deadline to apply to recruit participants, and a site's IRB failing to respond to the researcher. Of those who responded to the initial e-mail, only 10 training directors (6%) declined to forward the e-mail to supervisors. Their reason was overwhelmingly lack of time.

Clinical Supervisors

In total, 286 supervisors were personally contacted by the researcher via e-mail; 11 others (4%) could not be reached as the e-mails failed to deliver. Forty-eight supervisors independently contacted the researcher after learning of the study from their site's training director. In some cases, training directors were also providing clinical supervision and were therefore able to participate.

Of the 286 supervisors contacted by the researcher, 42 agreed to participate (15%); 26 did not qualify as they were not currently supervising clinical work (9%); 4 declined participating (1%); 6 expressed interest but then gave no further response (2%); and 208 did not respond to the e-mail (73%).

Of the forty-eight who independently contacted the researcher, 37 agreed to participate (77%); 4 were interested in participating, but did not meet the criteria for

inclusion (8%); and 7 expressed interest but did not follow up after the researcher replied (15%).

Actual Sample

A total of 144 sets of surveys – a set constituting a CFI and a Personal Therapy Survey numerically coded pair – were sent out to 79 supervisors. In a few cases, training directors asked that several sets of surveys be sent to them so that they could distribute them to the appropriate staff. The number of survey sets requested by each supervisor or training director varied from 1 to 9 sets. Fifty-six respondents requested only one set; 14 requested 2 sets; the rest requested 3 or more. One supervisor who had requested 3 sets responded to the follow-up e-mail, indicating that she could only complete one but was giving another set to another supervisor who might be able to participate. Another who had requested 6 sets replied that she did not supervise the interns closely enough to be able to complete the surveys, but would ask them to share the surveys with their individual supervisors. Another, who had requested 1 set, replied that she had misunderstood the study and did not meet the criteria. The final number of survey sets received was 57, leading to a return rate of 40% of the total (144) that were sent out. An additional 29 unmatched surveys were received; these were excluded from the study.

An absolute minimum of 15 dyads in each group was set which, according to Cohen and Cohen (1975) is enough to detect large differences. Though the goal was to have 30 dyads in each group, enough to detect large differences (Cohen & Cohen, 1975), the final sample consisted of 40 individuals who had had therapy after beginning their graduate training (70%) and 17 who had not (30%).

CHAPTER IV

RESULTS

All statistical analyses were conducted using alpha set a .05; all significance tests were two-tailed unless stated otherwise. For those analyses that required nonparametric statistical tests, only variable levels that included 5 or more cases were included. Means and standard deviations for all hypotheses are displayed in Table 1.

Table 1

Therapy After Beginning Training

	Mean for "Yes" (N=40)	Standard Deviation	Mean for "No" (N=17)	Standard Deviation
CFI Total Score	82.48	10.89	84.00	8.88
Self-Insight	19.23	2.63	19.00	1.58

The primary independent variable (IV) was whether or not the trainee had received personal therapy since beginning counseling training. Personal therapy was not limited to any particular modality, and could include individual, couples, or group therapy. The CFI Form-D subscales and scores from the subscale of self-insight comprised the dependent variables (DVs).

Hypotheses

Four hypotheses were postulated with regard to the role of personal therapy in countertransference management:

1. Having sought personal therapy since beginning graduate training in a counseling-related field will be significantly and positively related to countertransference management as measured by the five subscales of the CFI Form-D (CFI).
2. Longer duration of therapy (in sessions) will be significantly correlated with higher CFI total scores.
3. Having sought personal therapy since beginning graduate training in a counseling-related field will be significantly and positively related to countertransference awareness as measured by the self-insight subscale of the CFI.
4. Longer duration of therapy (in sessions) will be significantly correlated with higher scores on the self-insight subscale of the CFI.

A multivariate analysis of variance was conducted to address the first hypothesis – that having sought personal therapy (PT) since beginning graduate training in a counseling-related field would be significantly positively related to countertransference management as measured by the subscales of the CFI. The data indicated no significant relationship between the subscales and participants having a history of personal therapy after beginning their graduate training, Wilks' Lambda, $F(5,51)=.40$, $p=.85$, observed power=.14.

The second hypothesis – that longer duration of therapy would be significantly correlated with higher total scores on the CFI – was tested via correlational analysis. The data revealed no significant relationship between total scores on the CFI and length of therapy ($r=-.15$, $p=.35$).

A t-test was conducted to address the third hypothesis – that having sought personal therapy since beginning graduate training in a counseling-related field would be significantly and positively related to countertransference awareness as measured by the self-insight subscale of the CFI. No significant relationship was found between these two variables, $t(55)=.33$, $p=.74$.

The fourth hypothesis – that longer duration of therapy would be significantly correlated with higher scores on the self-insight subscale of the CFI - was tested by means of correlational analysis. The results did not reveal any significant relationship between the subscale and duration of therapy, $r=-.07$, $p=.69$.

Individual t-tests were also conducted on the remaining subscales to further attempt to discern any possible significance between those who had sought therapy after beginning their graduate clinical training and those who had not. These also failed to show any significant differences between the two groups for self-integration, $t(55)=-.79$, $p=.43$; anxiety management, $t(55)=-.78$, $p=.44$; empathy, $t(55)=-.45$, $p=.66$; and conceptual skills, $t(55)=-.59$, $p=.56$.

Qualitative Findings

All participants who reported having experienced personal therapy after beginning their graduate training responded to the open-ended question asking them to

identify the way(s) in which their therapy had impacted their own clinical work (see Appendix C). With the exception of 3 respondents who reported no impact of personal therapy on their own development as a therapist, the remaining 37 all reported positive effects of their therapy related to increased empathy; improved boundaries with self and others; greater awareness of self and countertransference/transference processes; and increased ability to attend to and use the therapeutic relationship constructively, including greater use of self. Responses of those who did not feel their therapy had positively impacted their clinical work included, "Not at all," "I don't feel one has anything to do with the other in my case," and "My therapy was not very helpful - I tried to minimize my issues and I think she did, too." This latter person went on to describe how she had learned from this experience to avoid doing the same in her own clinical work.

Twenty-eight supervisees reported that their personal therapy had facilitated greater awareness, either with regard to personal issues or with countertransference/transference phenomena. Eleven reported generally increased self-awareness, with comments such as: "I believe my experience in therapy has helped tremendously identify issues or reactions"; "I have become aware of how I get stuck in seeing clients/issues in a certain way"; "The therapy helped highlight my personal and intellectual needs from people"; "I think that I am far more aware of how my family-of-origin issues have influenced my perspective and reactions." Seven supervisees described a general heightened awareness of countertransference and transference: "I am more aware of countertransference"; "I gained an understanding of the phenomenon of transference as a client"; "My awareness of countertransference/transference issues is greatly increased." Ten supervisees described a more specific gain in awareness of their

own countertransference: "My personal therapy has…allowed me to be aware of when my own issues are being triggered"; "My therapy has made me aware of how my own issues could impact my work. I am now able to identify my countertransference issues and my issues interfere less with my work"; "Therapy…has increased my awareness of when my own issues begin to creep into my delivery of therapy."

Fifteen supervisees related that their personal therapy had helped them gain in empathy. Nine reported that it had helped them become broadly more empathic as therapists: "I am more empathic as a therapist"; "[I am] better able to empathize with my clients"; "I am more empathic, I connect better with clients." An additional six described having specifically gained increased empathy with the role of a client: "I also am more sensitive and empathic to the needs of my clients, having experienced the vulnerability of being a client myself"; "Increased awareness of (and sensitivity to) anxiety related to discussing personal issues with another person"; "I'm more understanding of what it is like to come into a counselor's office, be asked a lot of personal questions and not know anything about the person you're talking to."

Another common theme was that of reduced countertransference behavior, or conversely, increased countertransference management, especially in the form of improved boundaries. Four reported generally decreased acting out of countertransference reactions: "I…display less behavior related to my own countertransference"; "This awareness helps me stay focused on clients and not get "pulled in" to my own stuff during sessions"; "Therapy has significantly decreased the way in which my personal issues affect my clients in therapy." Seven respondents described a more specific management around boundaries: "Maintaining differentiation

and boundaries within the therapeutic stance. To know what is my issue versus the clients'"; "I am better able to be empathic... without becoming overly involved in the emotional lives of others"; "I am more…able to separate my own issues (which I deal with on my own time) from those of my clients."

Many supervisees reported both a greater awareness – and appreciation - of self-in-relation in the therapy relationship, as well as the ability to use both in their clinical work. Five described this increased appreciation of their role in the therapy encounter and the impact on the therapy relationship: "I am much more aware of my impact on my clients and their impact on me"; "I believe I have become much more insightful about how my values affect my therapy approach and how I related to my clients"; "I'm more attuned to process issues…I believe that the relationship is the primary healing agent of therapy." Four described their greater use of 'self' in therapy: "[I] am comfortable being more transparent with clients"; "My personal therapy has allowed me be aware of when my own issues are being triggered...so as to use them appropriately in the therapy process"; "Therapy has helped me be more present with patients and enabled me to use my feelings as a signal to how my patients are in the world and how others may experience them."

Six supervisees described the general value of their therapy: "I see how valuable therapy can be"; "My own personal therapy work has had a profound impact"; "I think that it helped tremendously. I plan on beginning therapy again soon to address personal issues but also because of how much I think it helps me to be a better therapist."

Five supervisees reported that therapy provided a valuable model for clinical work: "Provided me with a model for how to do therapy"; "Having a personal

experience with therapy helps to clarify what is expected during a therapy session…A personal experience with therapy provides a therapeutic role-model."

A few supervisees reported increased awareness of limits. One person wrote, "I believe that I can only take clients as far in therapy as I am willing to go myself." Two others described an awareness of the limits of therapy: "[My therapy] allowed me to understand what therapy can/cannot do"; "It gives the opportunity to experience what works during therapy, what missed the mark."

Three supervisees reported that therapy had given them a greater acceptance of the (sometimes lengthy) process of therapy: "learning…to measure progress in small (sometimes tiny) steps"; "I have also become an increasingly patient therapist due to my personal experiences in therapy."

Two reported that therapy had helped them make better use of supervision: "Helps me… increase my willingness to explore these (potential countertransference responses) in supervision"; "[I am] able to consult when personal issues may cloud judgment."

Two supervisees mentioned that they had gained in confidence as a result of their personal therapy: "The experience of growing with my therapist also helped me gain confidence in my own work"; "My own therapy allowed me to address issues of self-doubt, lack of assertiveness, and gender identity issues, all of which helped me to feel confident, secure, and assertive as a therapist."

Two reported that therapy had influenced their career choice: "Therapy was also instrumental in helping make career decisions to do clinical, not research work in my

practice"; "I initially started therapy to help in the decision process of whether or not to begin doctoral studies in Psychology."

Two reported that therapy had helped relieve stress from personal issues: "Not as stressed out so less distracted and able to focus more on my work"; "Helped deal with personal issues at the time to reduce possibility of impact on clinical work."

Several topics were mentioned by only one person. These were mostly descriptions of specific benefits from personal therapy: "It has made me less defensive about acknowledging my own concerns and owning them"; "Knowing more about myself…has enabled me to handle the emotion of my clients more effectively. I have become more accepting of diverse views"; "My personal therapy has allowed me to go deeper with my clients"; "Ethically, my delivery of services has improved due to increased awareness and more effective self-care as well."

Additional Analyses

Additional exploratory analyses were conducted to allow for anything outside the purview of the original hypotheses-related analyses to emerge. Relevant group means for all exploratory tests are reported in Tables 2-5 at the end of this section.

As testing for a relationship between personal therapy after beginning graduate training and CFI subscale scores did not reveal any statistically significant differences, the former was broadened to include respondents who had *ever* had personal therapy. This also did not result in any significant differences, $t(55)=.20$, $p=.84$. Individual subtests were also tested against this group in a multivariate analysis of variance, and the

data revealed no significance for the subscales, Wilks' Lambda, $F(5,51)=.27$, $p=.93$, observed power=.11.

Potential relationships between participants' demographic variables and their CFI total scores were also explored. Ethnicity was not included in this set of analyses as the minimum expected cell size was not met. The data revealed no significant differences in total scores by gender, $t(55)=1.42$, $p=.16$. Relationships with individual subscales were also explored, and similarly did not yield any significant results for gender, Wilks' Lambda, $F(5,51)=1.07$, $p=.39$, observed power=.35. There were also no significant correlations found by age and CFI score, $r=.20$, $p=.13$, nor by age and self-insight, $r=.24$, $p=.07$; self-integration, $r=.18$, $p=.19$; anxiety management, $r=.08$, $p=.58$; empathy, $r=.20$, $p=.13$; or conceptual skills, $r=.13$, $p=.34$.

The demographic variables of gender and age were also examined with regard to respondents' histories of personal therapy. Again, ethnicity was not included in this part of the analyses, as the numbers represented in the various ethnic groups were insufficient for any analysis to be meaningful. A two-way contingency table analysis was conducted to evaluate differences between gender and therapy history. Results indicated no statistically significant differences for having sought therapy after beginning therapy training, Cramer's $\underline{V}=.067$, $p=.615$, nor for having sought therapy at any point, Cramer's $\underline{V}=.026$, $p=.846$. Age was also not found to be significantly related to whether respondents ever sought personal therapy, $t(55)=1.88$, $p=.07$. Age was, however, found to be significantly related to whether respondents sought therapy after beginning their training, $t(55)=2.29$, $p<.05$.

Potential relationships between participants' primary theoretical orientation and their history of personal therapy could not be examined due to failure to meet minimum expected cell size. As with length of therapy, this was also the case for relationships between respondents' primary clinical orientation and that of their therapists'.

Length of therapy was examined with regard to the remaining subscales as well. No significance emerged for self-integration, $r=-.18$, $p=.26$; anxiety management, $r=-.29$, $p=.07$; empathy, $r=-.02$, $p=.89$; or conceptual skills, $r=-.20$, $p=.21$. The relationship between length of therapy and respondents' primary theoretical orientation could not be examined due to failure to meet minimum expected cell size. This was also the case for respondents' therapists' primary theoretical orientation and the length of respondents' therapy experiences. Secondary orientations cell numbers for both groups were even lower than for primary orientations and were thus also not considered for analysis.

The length of time that had passed since therapy ended was examined with regard to CFI total scores and individual subscale scores. No significant differences were found for CFI total scores, $r=.15$, $p=.34$, nor for self-insight, $r=.17$, $p=.31$; self-integration, $r=.05$, $p=.76$; anxiety management, $r=.29$, $p=.07$; empathy, $r=.11$, $p=.48$; or conceptual skills, $r=.11$, $p=.49$.

Table 2

Group Means For Participants Who Received Therapy After Beginning Training

	Mean for "Yes" (N=40)	Standard Deviation	Mean for "No" (N=17)	Standard Deviation
Self-Integration	15.60	2.43	16.12	1.76
Anxiety Mgmt.	7.83	1.39	8.18	1.88
Conceptual Skills	15.68	2.78	16.12	2.15
Empathy	24.15	3.50	24.59	3.12

Table 3

Group Means For Participants Who Received Therapy At Any Point

	Mean for "Yes" (N=46)	Standard Deviation	Mean for "No" (N=11)	Standard Deviation
CFI Total Score	83.07	10.35	82.36	10.45
Self-Insight	19.17	2.46	19.09	1.92
Self-Integration	15.78	2.34	15.64	1.91
Anxiety Mgmt.	8.00	1.40	7.64	2.11
Empathy	24.33	3.35	24.09	3.62
Conceptual Skills	15.78	2.64	15.91	2.51

Table 4

Group Means For Participants: Gender

	Mean for Males (N=14)	Standard Deviation	Mean for Females (N=43)	Standard Deviation
CFI Total Score	79.57	10.95	84.02	9.94
Self-Insight	18.00	2.51	19.53	2.20
Self-Integration	15.21	2.15	15.93	2.27
Anxiety Mgmt.	7.86	1.66	7.95	1.53
Empathy	23.29	3.95	24.60	3.15
Conceptual Skills	15.21	2.42	16.00	2.65

Table 5

Group Means For Participants: Age

	Mean (Total)	Standard Deviation	Median
Therapy After Beginning Training (N=40)	32.60	7.40	30.00
No Therapy After Beginning Training (N=17)	28.41	1.97	28.00
Therapy After Beginning Training Without Outliers (N=35)	30.29	4.03	29.00

CHAPTER V

DISCUSSION

The results of this study failed to support the hypotheses put forth about the relationship between personal therapy and countertransference. The experience of personal therapy for psychology supervisees after beginning graduate training did not appear to have an impact on either their supervisors' assessments of their self-awareness, or more broadly, countertransference management, nor did the length of the therapy. There was also no relationship between those who had been in therapy at any point in time and the abovementioned variables. Furthermore, the additional analyses did not reveal any relationships between the demographic variable of gender and having sought personal therapy, whether after beginning graduate training or at any point in time. Further analyses also did not reveal any relationships between age and gender and CFI scores, neither total nor individual subscale scores. Length of therapy also did not emerge as related to remaining subscales of self-integration, anxiety management, empathy, and conceptual skills. Time passed since therapy was not found to be related to countertransference management, nor any specific aspects of it as measured by the subscales of the CFI.

The percentage of therapists who sought therapy in this sample was similar to those of other studies. Of the 1,018 graduate clinical psychology students surveyed by

Holzman, Searight, and Hughes (1996), 74% had received personal therapy, with an average duration of 75 weeks. Pope and Tabachnick (1994) surveyed 476 practicing therapists, and 84% had been in therapy, with a median duration of 4 years. Seventy-one percent of the 710 therapists who participated in Norcross, Strausser-Kirkland, and Missar's (1988) study of personal therapy reported at least one experience of therapy. The average length for this experience was 171 hours, with a median of 50. Mahoney (1997) found that 88% of 155 clinicians had sought therapy. Finally, in MacDevitt's (1987) sample of 185 practicing therapists, 80% had sought therapy. Additionally, the reasons endorsed by participants for seeking therapy reflect existing literature. The majority of supervisees in this study endorsed "For Personal Reasons" as the main reason they sought therapy. The percentage of respondents who endorsed seeking therapy primarily because it was required by their training program was very low, which is also consistent with existing literature. Previous research has found that reasons for seeking therapy have primarily been personal (55%), personal and professional (35%), and primarily for training purposes (10%) (Pope & Tabachnick, 1994). Holzman, Searight, and Hughes (1996) found that over 70% of their respondents endorsed 'personal growth' as the reason for seeking therapy. Sixty-five percent endorsed a desire to improve as a therapist, and 56% endorsed adjustment or developmental issues (participants were allowed to endorse more than one option).

While it did not appear to have a significant impact on the results of this study, gender has, in other studies, been shown to play a role in therapy history. Norcross, Strausser-Kirkland, and Missar (1988) found that more female than male therapists had sought therapy. Across the professions of psychology, social work, and psychiatry, the

range of women who had sought therapy was 60%-84%, compared to 58%-71% of the men. Pope and Tabachnick (1994) reported that 90% of female therapists had sought personal therapy as compared to 80% of their male counterparts. Deutsch (1985) found that more female than male therapists reported use of personal therapy and medication for relationship and depression problems. Mahoney (1997) conducted a study on psychotherapists' personal problems and self-care patterns, and found that women reported having sought personal therapy significantly more frequently than men.

Though age did not emerge as related to having sought therapy at any point in time, it was significantly related to whether respondents sought therapy after beginning their training: on average, those who had sought therapy since beginning their training were older than those who had not. Though no relationships were hypothesized, this may suggest that the older students are when beginning their programs of study, the more likely they are to seek therapy, possibly because life experience has taught them the value of self-reflection. It may also be a spurious result stemming from older doctoral students perhaps having gotten a master's degree before seeking the doctorate; in this case there would be considerably more time for therapy to have occurred since beginning training. In other words, a 27 year old doctoral student has only had 5 years since starting graduate training; a 37 year old doctoral student may have had 15 years since starting their training, if she or he obtained a master's degree and then practiced for a while. Thus the greater number of older respondents reporting therapy since graduate school may be a spurious result of the time elapsed since beginning graduate studies. Since the vast majority of those who had sought therapy after beginning their training were under age 40, it may also suggest a cohort effect. It may be that, up until approximately age 40, the

older graduate students in counseling-related programs are, the more likely they are to have sought therapy after beginning their training. In other words, a 33-year-old therapist would be more likely to have sought therapy after beginning training than would a 22-year-old therapist. This would be consistent with Norcross, Strausser-Kirkland, & Missar's (1988) findings that the average age for the first, second, and third therapy experiences was 27.6, 30.5, and 38.6, respectively. Pope and Tabachnick (1994), however, found that the likelihood of being in therapy decreased with age. Nearly 93% of therapist 40 years old and younger were or had been in therapy, but only 85% of those in their forties were or had been, and only 81% of those over age fifty.

All in all, this study stands out in the sheer number of non-significant results. The discussion frequently turns to power and sample size when this occurs; however, there is no suggestion that a larger sample size would have made a difference in these results. The difference in means for the two groups (those who had experienced personal therapy after beginning graduate training and those who had not) across CFI total scores and individual subscale scores was very small (see Tables 1-5), and was in some cases slightly in the opposite direction to that expected given the hypotheses. These kinds of findings are perplexing, especially given the overwhelmingly consistent belief among respondents - evident in their open-ended responses - that their personal therapy did positively impact their therapeutic effectiveness. Several potential explanations will be considered individually below.

The Hypothesized Effect of Personal Therapy Does Not Exist

One possibility certainly is that the expected effect does not exist. Personal therapy for the therapist may very well not have any impact on the quality of the therapist's clinical work. The fact that personal therapy was not shown to have any relationship to self-awareness or any other aspect of countertransference management in this study is in direct contradiction to what would have been expected given existing theoretical and empirical literature, though limited. This was the case even when just a history of ever having sought out personal therapy was examined, rather than the narrower requirement of having experienced therapy after beginning one's graduate training.

Therapists' positive perceptions of their therapy and its impact on their clinical work, both in this and previous studies, would seem to indicate that a history of personal therapy would translate to greater self-awareness in the therapy room. In this study, a high number of therapists who had experienced personal therapy reported that this therapy had been helpful in ways related to self-awareness, countertransference awareness, and improved countertransference management. This perception is consistent with previous studies. The therapists surveyed by Norcross, Strausser-Kirkland, and Missar (1988) about their personal therapy experiences frequently described one of their lasting lessons from their personal therapy as the importance of transference, countertransference, and unconscious motivations and material. Macran, Stiles, and Smith's (1999) in-depth qualitative multiple case study of practicing therapists revealed that they tended to translate personal insights from therapy into awareness of boundaries and of the areas and types of clients that generally caused them difficulty. Wiseman and

Shefler's (2001) study of psychotherapists revealed that personal therapy was seen as helping them improve their self-awareness, which was valued because of its perceived influence on their clinical work. A common perception of personal therapy found in the literature is that of increasing the therapist's self-awareness with regard to dynamics and conflicts and facilitating improved countertransference management from clearer perceptions (Norcross, Strausser-Kirkland, & Missar, 1988). Other studies have found similar patterns (Kaslow & Friedman, 1984; Rosenberger & Hayes, 2002).

Even the few quantitative studies that have investigated the role of personal therapy in professional development and functioning have found that a relationship appears to exist between the two. Though not specific to countertransfence, Peebles' (1980) study of advanced clinical psychology doctoral students is relevant to this discussion, as she was able to demonstrate a positive relationship between numbers of hours of personal therapy and an ability to be empathically accurate and engage genuinely in session, both of which are abilities that require awareness of feelings, including an ability to differentiate among a variety of emotions. MacDevitt's (1987) study of practicing clinicians clearly suggested that having experienced personal therapy – and the more the better – would be associated with high self-awareness, particularly as it related to countertransference. MacDevitt's experimenter-designed questionnaire (the TVQ) contained psychotherapy vignettes and multiple potential responses to each, one of which measured countertransference awareness (CA). Participants had to choose the one that best fit how they would handle the situation among these options. The following are sample items:

1) This patient has bored, disgusted, and frustrated you since beginning treatment and you dislike him/her.

A. Some patients are just plain repulsive or obnoxious, and you realistically cannot expect to like every patient you treat.

B. Look into your relationship with this patient.

C. Refer this patient.

D. Tell this patient your reactions.

E. A patient who induces such reactions in you probably deserves your dislike.

2) You have been seeing Mrs. R., a forty-year-old housewife, for four months. She asks you about each little decision she makes in her life. She flatters you and tells you how important you are to her. When you are going out of town for a week she is beside herself with fear and grief. At first this degree of involvement on her part is pleasing to you, but eventually it disgusts you. You come to dread seeing her.

A. Express your feelings to her; they would probably be very valuable feedback for her, and might encourage her to be more appropriate in therapy.

B. She should behave better than this.

C. Don't blame yourself for your reaction; she probably affects others in the same way.

D. Turn your focus inward to understand your strong reaction to this woman.

E. Before each session with her, mentally rehearse being unmoved by her behavior.

In the first example, the CA response is B; in the second, it is D. A count of the frequency with which a participant selects the CA option constitutes their

countertransference awareness score. MacDevitt correlated the CA score with aspects of therapists' history of personal therapy, as well as other variables deemed relevant for the study of countertransference awareness (therapists' clinical orientation, therapists' therapists' clinical orientation, number of hours providing therapy weekly, etc.). He found that number of therapy hours received was the only variable that made an independent contribution to CA; it also made an independent contribution to the perceived value of personal therapy. As with all survey studies, however, it is difficult to say to what degree therapists' responses reflected their actual reactions in real-life. Since the TVQ was developed specifically for the study, and hence had little history to support its use to measure CA, it is possible it is not a valid measure of CA. Alternately, the TVQ may be measuring a valid construct related to CA, but one that is different from what the CFI measures. The TVQ may be measuring a more general tendency to self-reflect rather than more specific aspects of countertransference. The TVQ may help access therapists' propensity for including 'self' in the therapeutic equation (e.g., "Am I playing a part in this client's behavior?"), whereas the CFI may, in theory, help discern more specific details of that propensity (e.g., "How might I be contributing to this client's behavior?"). Though the experimenter attempted to conceal the interest in CA through inclusion of several vignettes for which the CA options would have been blatantly irresponsible (such as a vignette in which a client has announced his plan to kill another person), participants may nonetheless have discerned the purpose of the survey, and their responses might have been influenced by social desirability. This would, of course, make the validity of the results questionable. A key difference between the two instruments is also the fact that the CFI uses ratings by others. While the TVQ is not a

self-report measure, it did not employ any outside ratings of countertransference awareness, and this may also partially account for the different results obtained from the two studies.

While the lack of a demonstrated relationship in this area is puzzling, it is not completely unheard of. Some authors have suggested that personal therapy may not have any effect on countertransference phenomena. Their studies, unfortunately, lend little in the way of clarification of the results of this study due to methodological limitations. In one of the original studies of countertransference, Cutler (1958) found that neither varying levels of experience nor the experience of personal analysis made any difference in the accuracy of therapists' reports of their own and their clients' behavior. The problem with this study lies primarily in its sample size; only two therapists were involved in the main part of the study – one who had completed analysis, and one who had not experienced any personal therapy. In spite of the small sample size, Cutler's study is valuable in that he devised a means of accessing internal conflicts. Cutler used self-vs.-judge ratings, in which he compared therapists' self-ratings on certain personality traits with ratings of the therapists by others (judges) on the same traits, to identify therapist conflict areas. He translated this to the clinical realm by having therapists rate themselves and their clients after each of several sessions, and compared these ratings to those discerning countertransference behavior from the tape-recorded sessions. He hypothesized that therapists would over- or underemphasize certain traits based on distortion in self-perception due to conflict, and that therapists' responses to client behavior that was conflictual for them would be less adequate than to conflict-free behavior.

Clark's (1986) review of the empirical literature concerning the usefulness of therapy and the effects on client outcome also failed to shed much light on the findings of this study. It should be noted that none of the studies reviewed by Clark (1986) explored whether personal therapy would positively impact client outcome by specifically reducing countertransference. Based on his review of seven studies, Clark concluded that personal therapy for the therapist could not be shown to be beneficial to client outcome. Several caveats bear mentioning, including the fact that the studies reviewed failed to consider the motivation for the clinician to have sought therapy, the point in the clinician's career that therapy occurred, and whether or not therapists' level of disturbance was assessed and controlled. Clear descriptions of client outcome ("patient improvement" or "patient's final status") in each study were also missing from the review. These variables will be explored briefly below; therapist level of disturbance will be explored later in this section.

While most seek therapy for primarily personal reasons, as described earlier in this section, these findings were obtained during the late 1980s through the mid 1990s. Given that Clark completed his review in the mid 1980s and that most of the literature reviewed was from the 1960s and 1970s, it is possible that more therapists were trained analytically and, therefore, sought therapy primarily because it was required by their program of study. This may well have impacted their motivation to engage in analysis. Additionally, motivation to make the most of therapy regardless of the reason for seeking it out, will also vary from person to person and may also affect the level of change experienced.

The point in a therapist's career at which she or he seeks therapy is important because of the impact it may have on how well the therapy is integrated into their professional functioning. This notion was part of the rationale for choosing pre-doctoral interns and beyond as participants in this (dissertation) study and specifically examining the experiences of those who had begun personal therapy after beginning professional training.

While Clark did not mention how client outcome was defined in each study reviewed, this could be an important variable in the conclusion drawn from the review, as outcome could be determined in any number of ways. Much like 'countertransference,' 'outcome' can suffer from ambiguous and varied definitions.

The Hypothesized Effect Is Too Subtle To Be Measured

It could also be the case that the hypothesized effect does indeed exist but is too subtle to be discerned, either by supervisors or by this instrument. It may be that the quality of the difference that personal therapy engenders is so small that it cannot reasonably be measured. If that is the case, one has to wonder about its importance in the overall list of determinants of quality clinical work. Macaskill (1988) suggested that it may only be in those therapy dyads in which the client is particularly disturbed in an area that evokes significant conflict for the therapist that personal therapy has an effect on client outcome. The same may hold true for countertransference. In other words, the 'neutralizing' effect of personal therapy on countertransference awareness and/or management may only emerge under circumstances of highly unfortunate therapist-client matching. This would, of course, limit the accessibility to the phenomenon. The type of

countertransference would also figure into this. If therapists experienced more chronic countertransference reactions – reactions that occur almost indiscriminately across clients – as opposed to the sporadic quality of acute countertransference – to particular clients or issues (Hayes & Gelso, 2001), it may be more likely to show up regardless of the therapist-client match.

Research on the CFI has generally shown it to measure components of countertransference management and to possess adequate reliability and validity (see Chapter 2 for a complete review). If there is a shortcoming with the instrument, it may be that some of the items require knowledge of internal states to which most supervisors would not have access. This is unlikely in this study, however, as the form of the CFI used was selected specifically because of its focus on more easily observable qualities rather than requiring knowledge of supervisees' internal processes. It is somewhat more likely that not all supervisors would equally *attend* to countertransference management processes, in general, and countertransference awareness, specifically. A cognitively-oriented supervisor, for example, is probably less likely to attend to fantasies triggered by client material than is a psychodynamically-oriented one. While the five items that measure self-insight on the CFI ("is often aware of feelings elicited in him/her by clients," " is often aware of fantasies in him/her triggered by client material or affect," "usually comprehends how his/her feelings influence him/her in therapy," "recognizes the limits of his/her clinical competencies," and "is willing to consider him/herself as an impediment to client progress") ask for information that should, reasonably, be accessible in supervision, they do nonetheless require knowledge of internal processes. As supervisors' theoretical orientation was not measured in this study, it is impossible to

discern how this variable might have impacted the results on the self-insight subscale in particular. Given the fact that no relationship was discerned for the remaining subscales either, it is unlikely that supervisor clinical orientation would have produced different results. The limited research using the CFI has also not reported any difficulty with the self-insight subscale and ratings by others (Gelso, Fassinger, Gomez, & Latts, 1995; Gelso, Latts, Gomez, & Fassinger, 2002). The type of supervision might also have an impact on supervisors' abilities to discern supervisees' countertransference. Supervision varies and could consist of anything from tapes (video or audio) to self-report or the use of case histories. The amount of contact with one's supervisee likely also varies and could impact the quality of the supervision.

Personal Therapy Evens the Playing Field For More Disturbed Clinicians

Another potential explanation of the results is the possibility that more disturbed people are the ones who seek therapy, and thus, rather than improving their clinical skills, their therapy serves more as a means of 'leveling the playing field' with regard to other clinicians who are less disturbed. This was suggested by Macran and Shapiro (1998) in their review of the role of personal therapy for therapists. While therapist pathology was not assessed in this dissertation study, it is certainly possible that those therapists who had sought therapy were more disturbed initially than were those who had not sought treatment. If this were the case, it might explain the discrepancy between therapists' positive perceptions of their personal therapy and the results of the CFI ratings; for these therapists, therapy was indeed positive, and helped them attain a level of healthy adjustment that they may not have had without it. They may, in other words, believe

correctly that their clinical skills were improved by therapy, but these gains served only to bring their therapy skills up to part with those of less disturbed therapists. This notion was explored by Garfield and Bergin (1971) when they obtained results contradictory to their hypothesis. They wondered if the negative client outcome scores obtained for therapists who had had longer experiences in personal therapy were due to a greater degree of disturbance in this group. However, when they looked at certain scales on the MMPI, which all participants had completed, they found no differences in the amount of therapy received by the more and less disturbed therapists as assessed by the MMPI. This suggested that therapist level of disturbance was not the reason for the poorer client outcome scores. They also noted their belief that therapists who had engaged in longer personal therapy would be more likely to admit to pathology on the MMPI, and because this did not happen, they felt it provided further evidence that therapist pathology was not the variable of interest.

Summary

The question of whether personal therapy has any measurable and/or meaningful impact on countertransference awareness is a complicated one. There is some empirical literature suggesting that it does; however, this literature is limited and not as methodologically sound as one might wish. It is difficult to know if MacDevitt's study and its findings, which are both a basis for this dissertation study and also the main source of support for this notion, are indeed valid, both in terms of the construct it purports to measure and the instrument used. At this point, it can only be noted that his findings stand in sharp contrast to those obtained in this study. In qualitative studies, the

evidence for therapy's positive impact on countertransference awareness is much stronger, but again, methodological limitations prevent us from claiming with greater certainty that therapists' perceptions are accurate. As the common thread running through these studies is the self-report nature of the data, the potential bias cannot be ruled out, and it may be the case that the results obtained in this current study are a more accurate reflection of countertransference awareness and management. Alternately, self-report may allow for greater access to the nuanced effects of personal therapy in a way that other methods, including supervisor ratings, cannot; this is particularly relevant for the study of countertransference, as it is a complicated phenomenon and frequently an internal experience. Finally, unrelated to methodological considerations, the possibility remains that personal therapy does indeed help to reduce countertransference, but only insofar as it brings more disturbed therapists up to the same level of countertransference awareness and management as healthier therapists.

Limitations and Implications for Future Research

Regardless of the reason, the results of this study clearly show that, if an effect of personal therapy on countertransference awareness and/or management does indeed exist, it was not detected. This particular study was subject to the possibility of selective responding that always haunts survey-based investigations. Nonetheless, the sample is believed to be representative of the population and the response rate was within the range of what would be expected for this kind of study. There is no reason to believe that the response rate would be selective such that responding supervisees who had been in therapy would be significantly different from the population of supervisees who have

been in therapy, nor that respondents who have not been in therapy would differ from their respective population. Similarly, there is no reason to believe that supervisors' ratings were systematically biased for any reason. Assessing supervisors' theoretical orientation, however, would have helped to rule out the impact of this variable on CFI ratings. A larger sample would also have allowed for analyses of supervisees' – and supervisors' - theoretical orientation, as well as that of their therapists', both of which could reveal valuable information that might affect the results in unexpected ways.

One of the difficulties with studying this particular area is the complexity of the construct involved. In general, research on countertransference has been hindered by the lack of a clear operational definition and the multifaceted and nuanced quality of the construct; this has, of course, made it difficult to measure as well (Gelso & Hayes, 1998; Rosenberger & Hayes, 2002). In addition, there are a number of ways besides personal therapy that interns can increase countertransference awareness. This high variety, along with the fact that countertransference awareness is so hard to measure, can make it difficult to find significant effects from only one factor, in this case, therapy.

One consideration when looking at the results of this study and planning future research is both the timing of the data collection and the nature of the supervisor-supervisee relationship. The fact that the data in this study was collected in the fall semester/quarter may very well have meant that there may not have been time for supervisors to get to know their supervisees well enough to detect countertransference. In the spring, supervisors have a much better idea of supervisees' growth edges and areas of unresolved conflict. The feedback from the fall supervisor is available to the spring supervisor as well. A potential problem with internship sites in particular is that, due to

the many demands of internship, they may not have the time for detailed supervision, which could inhibit the supervisors' ability to assess countertransference in the supervisee. Additionally, internship supervisors only know their supervisees for a year (in this case, approximately 3 months). In doctoral programs, however, campus supervisors may know students for years. Again, supervisors may then have a better chance of being able to detect and report countertransference phenomena within their supervisees. Even if the best-case scenario is obtained with regard to these variables, the question whether supervisor rating is the best and/or most realistic way to measure countertransference awareness can be asked here. Countertransference is such an internal process, and is by its nature, frequently unconscious. This inherently makes it difficult for even the most astute, attentive supervisor to detect countertransference in a supervisee. Furthermore, even if awareness of aspects of one's countertransference is gained, this may not be shared in supervision.

The results and limitations of this study suggest that future research should approach this area in a somewhat different way. A sound study of personal therapy and countertransference would need to control for therapist level of disturbance, level of experience (e.g., first-semester therapist-in-training versus intern and beyond), size and type of caseload, pre-therapy existing levels of psychological-mindedness and/or motivation to heighten self-awareness, and previous history of personal therapy.

One scenario for determining whether personal therapy has any relationship to countertransference awareness and/or management would be to randomly assign therapists to either a 'therapy' or a 'no therapy' condition in an experimental design. Participants' countertransference awareness should be assessed at the beginning and end

of the study. This design would allow for control over the previously mentioned variables and a greater degree of certainty in the results. Participants should not have a history of personal therapy, as this could potentially contaminate the effects of the manipulations. This would also make less advanced therapists (i.e., practicum students) more likely candidates. With regard to assessment, using more than one method of measuring countertransference phenomena would increase the chances of obtaining valid results. If the CFI were to be used as a measure, having another – or several – measure(s) would also allow for the possibility of ruling out whether the flaw was in this particular instrument or in some other part of the study. By way of example, independent raters could review videotapes of sessions and assess countertransference behavior, therapists could report immediately after a session on their perception of the session, or therapists could review videotapes of their sessions and identify instances in which they were aware of their personal therapy having directly helped them with their countertransference. This latter example was suggested by Macran and Shapiro (1998). On the other hand, Hayes, McCracken, McClanahan, Hill, Harp and Carozzoni (1998) suggest that therapists may be better able to recall countertransference-related material if they are allowed time after the session to 'digest' it. Using therapists' post-session reviews can be a bit troublesome, however, as the unconscious nature of much countertransference inherently limits the completeness of the reports.

Another option would be to conduct a correlational study of therapists who have been in therapy and therapists who have not, much like this study. Given the methodological limitations inherent in this type of study, this method would not be recommended. If it were used, more attention should obviously be paid to controlling the

variables previously mentioned. Therapists participating should ideally be within a reasonable range of each other with regard to level of clinical experience. Therapist level of disturbance as well as psychological-mindedness should be assessed, and this could be done with any number of inventories measuring personality characteristics and personal pathology. Therapists' areas of conflict would also need to be assessed, possibly in a similar manner as that designed by Cutler (1958). It would also be important to attend to motivation for seeking therapy. Countertransference awareness could be measured in any of the ways described above.

The best way of investigating this type of phenomenon is likely within a longitudinal framework. Using pre- and post-tests, an investigator could observe changes in countertransference awareness within the individual therapist over time. This design would eliminate a lot of the aforementioned problems with researching this construct, though it carries with it its own threats to internal validity.

Regardless of how this area is investigated in future research, the results of this study do lend themselves to implications regarding personal therapy as a requirement for training. Coupled with the lack of prior evidence of significant benefit in client outcome, the results cast doubt on the value of requiring therapy for therapists in training. This study would suggest caution when programs are debating whether to require their students to enter therapy. Additionally, those programs currently requiring personal therapy for their graduate students may want to reconsider a requirement that typically involves great effort, financial resources, and time, and that may very well not produce better clinicians, at least not with regard to countertransference management.

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APPENDIX A

INSTRUMENTS

Countertransference Factors Inventory

Form D

Please rate the supervisee according to the following descriptions.
The "therapist" refers to the supervisee.

The therapist:	**Strongly Disagree**	**Disagree**	**Not Sure**	**Agree**	**Strongly Agree**
1. usually restrains him/herself from excessively identifying with the client's conflicts.	1	2	3	4	5
2. is often aware of feelings in him/her elicited by clients.	1	2	3	4	5
3. is usually emotionally "in tune" with clients.	1	2	3	4	5
4. 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
5. effectively sorts out how his/her feelings relate to client's feelings.	1	2	3	4	5
6. often sees things from the client's point of view.	1	2	3	4	5
7. is usually able to conceptualize client dynamics or issues clearly.	1	2	3	4	5
8. effectively distinguishes between client's needs and his/her own needs.	1	2	3	4	5
9. is often aware of fantasies in him/her triggered by client material of affect.	1	2	3	4	5
10. usually comprehends how his/her feelings influence him/her in therapy.	1	2	3	4	5
11. can usually identify dynamics of the counseling relationship.	1	2	3	4	5
12. recognizes the limits of his/her clinical competencies.	1	2	3	4	5
13. feels confident working with most clients.	1	2	3	4	5
14. can usually identify with the client's inner experience.	1	2	3	4	5
15. gets beyond the manifest content to the latent meanings of a client's verbalizations.	1	2	3	4	5

The therapist:	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
16. often uses his/her past experiences to aid in understanding the client.	1	2	3	4	5
17. is willing to consider him/herself as an impediment to client progress.	1	2	3	4	5
18. does not become overly anxious in the presence of most client problems.	1	2	3	4	5
19. is perceptive in his/her understanding of clients.	1	2	3	4	5
20. usually connects strands of the client's material.	1	2	3	4	5
21. often conceptualizes his/her role in what transpires in the counseling relationship.	1	2	3	4	5

Personal Therapy Survey

Age _____

Gender _____

Ethnicity ____ _____

What is your theoretical/clinical orientation? _____

Have you ever been in psychotherapy or counseling? _____

Were you ever in psychotherapy or counseling *before* you started your graduate clinical training?

_____

Were you ever in psychotherapy or counseling *during* your graduate clinical training?

_____

For the following questions, please answer with regard to the most impactful therapy experience that you had *after* you had begun your clinical training:

What was/is the theoretical/clinical orientation of your therapist? If unsure, please use your best judgment as to which orientation would best describe this therapist: _____ _____

_____ _____ _____ _____ _____ _____

How long was the therapy experience? _____ _____ _____ _____

What was the frequency of sessions (i.e. weekly, biweekly)? __ _____ _____

How long ago did this therapy experience end? _____ _____ _____

Please indicate which of the following best describes the *primary* reason you entered therapy:

it was required by my program _____ _____

for personal reasons __ _____ _____

to become a better therapist _____ _____

How do you think your own (personal) therapy work has impacted how your personal issues affect your delivery of services as a therapist? _ _____ _____ _____

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

APPENDIX B

E-MAILS SENT TO TRAINING DIRECTORS AND CLINICAL SUPERVISORS

E-Mail for Training Directors:

Dear Dr. [name],

I recently completed my internship at the University of Florida and am currently working to complete my dissertation. I am conducting my dissertation in the area of the therapist's reactions to clients/patients and her/his use of personal therapy. As my study involves clinical supervisors at APA-approved internship sites, I am hopeful that you would pass on to me the names and e-mail addresses of supervisors at your site who are currently supervising doctoral psychology interns' clinical work, or that of other clinicians who have completed internship but are still receiving clinical supervision (i.e. post-docs or ABD clinicians). I would then contact them with more information about my study and they can decide if they would like to participate. The study has been approved by my home institution's IRB (Auburn University, Project # 03-135 EX 0307); participation is anonymous. I would be more than happy to answer any questions you have about the study before you forward me the names of the clinical supervisors. If you prefer, I can send you the email I would otherwise send to them. You can contact me via email, or by phone at (336) 209-2734. Thank you so much for your consideration. I truly believe this is a worthwhile endeavor for all parties involved.

Sincerely

Linda Duthiers

E-Mail for Clinical Supervisors:

Dear Dr. [name],

I am writing to invite you to participate in a project that will examine the relationship between personal therapy and therapists' reactions to clients/patients (countertransference). It is a dissertation study being conducted by myself, Linda Duthiers, and my dissertation chair, Dr. Becky Liddle, of Auburn University. Your participation would entail completing a brief survey (approximately 10 minutes) on the psychology intern(s), post-doc(s) and/or ABD clinician(s) you supervise, and passing along to her/him a very short survey for their completion. Participation is anonymous for both supervisor and supervisee(s), and, of course, completely voluntary.

This area in our field has not been granted the attention it deserves, and I firmly believe that your participation would be an important step in filling that void. If you would like to participate, simply reply to this e-mail message and include your physical mailing address. I will then mail you the study materials with stamped envelopes for return. You can contact me via email, or by phone at (336) 209-2734. Thank you for your consideration.

Sincerely,

Linda Duthiers

APPENDIX C

RESPONSES TO OPEN-ENDED QUESTION

1) I am more aware of countertransference and it has made me less defensive about acknowledging my own concerns and owning them. I see how valuable therapy can be and I am more empathic as a therapist.

2) No therapy

3) I believe that I can only take clients as far in therapy as I am willing to go myself. I had/have difficulty expressing more vulnerable emotions. I have found that since working on this issue in therapy, I am able to help clients get in touch with those emotions, and display less behavior related to my own countertransference.

4) Allowed me to develop skills to cope with my problems, understand them, and take personal responsibility for them. Provided me with a model for how to do therapy. Allowed me to understand what therapy can/cannot do.

5) I am more aware of my own issues and how they might affect me as a therapist.

6) More awareness of the impact of my emotional state on others – I have a greater range of emotional comfort now, and am much more accepting of others (therapy, of life? Influence unclear). When I have the rare client interested in/ appropriate for insight-oriented work, I am much clearer on how to address this. Therapy was also instrumental in helping make career decisions to do clinical, not research work in my practice.

7) I initially started therapy to help in the decision process of whether or not to begin doctoral studies in Psychology. I believe my experience in therapy has helped tremendously identify issues or reactions and use appropriately in a therapy session.

11) No therapy

12) I have become more aware of how I get stuck in seeing clients/issues in a certain way; I am more able to change my mind/be flexible in my formulations; also I am learning to accept my mistakes and to learn from them; learning to be easier on myself; to measure progress in small (sometimes tiny) steps. Am comfortable being more transparent with clients.

15) The therapy helped highlight my personal and intellectual needs from people. I feel I'm aware (usually) of what I "need" from clients. This awareness helps me stay focused on clients and not get "pulled in" to my own stuff during sessions. The

experience of growing with my therapist also helped me gain confidence in my own work.

17) No therapy

19) No therapy

24) No therapy

26) Maintaining differentiation and boundaries within the therapeutic stance. To know what is my issue versus the clients'.

27) Not as stressed out so less distracted and able to focus more on my work.

30) I am much more aware of my impact on my clients and their impact on me. Knowing more about myself has enabled me to handle the emotions of my clients more effectively. I have become more accepting of diverse views. I am better able to be empathic without becoming overly involved in the emotional lives of others.

31) My personal therapy has allowed me to go deeper with my own clients/ allowed me to be aware of when my own issues are being triggered so as to use them appropriately in the therapy process.

32) No therapy

40) I gained an understanding of the phenomenon of transference as a client and it helped me to empathize with my clients when they have uncomfortable feelings around transference issues.

42) I am more aware of personal issues and am better able to empathize with my clients.

48) I am now much more aware of where my own personality comes into play in sessions with clients so their issues will not be mistaken for mine and vice versa.

49) No therapy

55) No therapy

68) No therapy

70) My own personal therapy work has had a profound impact – my awareness of countertransference/transference issues is greatly increased, ethically my delivery of services has improved due to increased awareness and more effective self-care as well.

71) My therapy was not very helpful – I tried to minimize my issues and I think she did, too. This has taught me to probe more and perhaps look deeper with my own clients even when things may seem simple. Work I have done on my own since therapy has been more useful in affecting the impact of my personal issues on my work as a therapist.

72) 1: positive impact 2: helps me recognize potential countertransference responses and increase my willingness to explore these in supervision. 3: greater empathy/understanding of clients' perspective.

73) I do think that I am a better therapist as a result of being aware of my personal relationship style and how this can affect my therapeutic relationships. In particular, I think I am aware of my own personal resistance to confrontation and conflict in my personal relationships and how this can play out in my therapeutic relationships.

76) I am more comfortable with myself, aware of my own inner experience, and able to separate my own issues (which I deal with on my own time) from those of my clients. I also am more sensitive and empathic to the needs of my clients, having experienced the vulnerability of being a client myself.

77) (No therapy) N/A but currently considering entering personal therapy while on internship to become a better therapist and to get a better understanding of patient/client role.

78) My therapy has made me aware of how my own issues could impact my work. I am now able to identify my countertransference issues and my issues interfere less with my work. Also, therapy has helped me be more present with patients and enabled me to use my feelings as a signal to how my patients are in the world and how others may experience them.

79) No therapy

83) Increased awareness (and sensitivity to) of anxiety related to discussing personal issues with another person.

84) More awareness of personal issues. Able to consult when personal issues may cloud judgment, less unconscious motivations for interventions.

85) Helped empathize with role as patient. Helped deal with personal issues at the time to reduce possibility of impact on clinical work.

88) More mindful of the issues that patients struggle with, increased empathic ability, increased awareness of transference issues.

89) I believe I have become much more insightful about how my values affect my therapy approach and how I related to my clients. I have also become an increasingly patient therapist due to my personal experiences in therapy.

95) I am a better therapist because of it. I had a great model to follow.

99) Not at all (person had 1 session lasting 1.5 hours)

102) I don't feel one has anything to do with the other in my case

103) I think that it helped tremendously. I plan on beginning therapy again soon to address personal issues but also because of how much I think it helps me to be a better therapist. My own therapy allowed me to address issues of self-doubt, lack of assertiveness, and gender identity issues, all of which helped me to feel confident, secure, and assertive as a therapist.

105) I has increased my insight into the therapeutic process and convinced me that the key, in my opinion, to therapy success is the therapeutic relationship.

106) Having a personal experience with therapy helps to clarify what is expected during a therapy session. It gives the opportunity to experience what works during therapy, what misses the mark, and how transferences can be resolved. A personal experience with therapy provides a therapeutic role-model.

111) It has made me more understanding/sympathetic of the anxiety you feel when first entering therapy and the difficulty with self-disclosure. It has made me more aware of how my own issues can come into the therapy hour.

113) I think that it makes me now think more about what I say as a therapist.

114) It makes me a better therapist.

115) No therapy

116) Therapy has significantly decreased the way in which my personal issues affect my clients in therapy and has increased my awareness of when my own issues begin to creep into my delivery of therapy.

117) Since I have not been in therapy they do not impact it, but I often feel that it would have been good to experience therapy first hand before doing it. Great idea for research, hope you obtain interesting results.

118) I am more empathic, I connect better with clients. I'm more willing to let clients make own life decisions, respect their decisions more. I'm more attuned to process issues and countertransference. I believe that the relationship is the primary healing agent of therapy.

119) I think that I am far more aware of how my family-of-origin issues have influenced my perspective and reactions. This aids my ability to be cognizant of my biases during assessments and interventions, which (hopefully) increases my ability to prevent them from impacting my work in a negative way.

120) Feel more connected to being a client in therapeutic relationship.

121) I'm more understanding of what it is like to come into a counselor's office, be asked a lot of personal questions and not know anything about the persona you're talking to. I also became more aware of some subtle things that can make the counseling process more or less comfortable while still providing the challenges needed to make progress.

122) Increased empathy and yet increased capacity to identify and maintain appropriate boundaries.

124) More sensitive

127) No therapy

131) It has made me more aware of their potential to have an impact.

142) No therapy