Can Countertransference Manifestations be Identified During Counselling Sessions?

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Abstract

This study investigated two main research questions: first, could countertransference manifestations, operationalized as counsellor over-involvement and under-involvement, be reliably identified by independent judges observing videotapes of actual therapy sessions; and second, was there evidence to support the contention that counsellor over-involvement and under-involvement were valid indicators of countertransference behaviour.

A multiple case study research design was employed to research this phenomenon. In order to respond to the second research question, this study had to determine whether the first research question could be answered with confidence. Thus, a methodology was employed for the first research question that maximized the reliability of measuring counsellor over-involvement and under-involvement. A generalizability (G) study was conducted to assess the dependability of the behavioural measure of countertransference. The G study helped to design the decision (D) study (e.g., how many counsellor-client dyads, sessions, and judges would be needed to obtain a reliable measure of counsellor over-involvement and under-involvement).

The D study included two counsellor-client dyads across eight therapy sessions. Three judges used videotapes and transcriptions of the sessions to rate each counsellor response for over-involvement and under-involvement using a 7-point Likert scale (i.e., -3 = under-involved; -2 = somewhat under-involved; -1 = possibly under-involved; 0 = empathically involved; +1 = possibly over-involved; +2 = somewhat over-involved; +3 = over-involved). This study confirmed that counsellor over-involvement and under-involvement could be reliably observed by independent judges. The average intra-class correlation across eight therapy sessions was .76 for Counsellor One and .79 for Counsellor Two. A moving averages graphing procedure was used to identify episodes where each counsellor's over or under-involved response departed from their individual baseline, using sessions with reliability coefficients greater than .75. These episodes were

used as the focus for research question two, investigating indicators of countertransference.

A Qualitative (Q) study was conducted to respond to the second research question. Data was collected from multiple information sources (e.g., episodes of over and under-involvement from session transcripts, counsellor session notes, supervision notes, and counsellor and supervisors ratings). These data were then analyzed qualitatively by triangulating the data and identifying themes. The results suggested that counsellor over-involvement and under-involvement are interpretable as valid indicators of countertransference behaviour.

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And now, I dance.....

Dance when you're broken open.
Dance when you've torn the bandage off.
Dance in the middle of the fighting.
Dance in your blood.
Dance, when you're perfectly free.

Rumi

Chapter I

Introduction

Sigmund Freud first wrote about countertransference in 1910; he described countertransference as the therapist's conflictual emotional reactions to a client's material that stemmed from unresolved issues in the therapist's unconscious (e.g., cited in Robbins & Jolkovski, 1987; Singer & Luborsky, 1977; Yulis & Kiesler, 1968). According to Freud and supporters of the classical psychoanalytic position, these reactions - the result of anxiety and defense - were deemed antithetical to the therapeutic process. The therapist was encouraged to understand his or her reactions to the client, either through supervision or analysis, so that their effects on the process could be minimized.

Over the years others have conceptualized countertransference more broadly, adopting what is often referred to as the "totalistic" perspective (e.g. Kernberg, 1965). From this view, all feelings and thoughts a therapist holds in response to a client, both conscious and unconscious, are called countertransference (e.g., Heimann, 1950). These feelings are thought to increase the therapist's understanding of the client and facilitate the empathic process. In other words, in this view countertransference is seen as an important therapeutic tool, essential to client growth (e.g., Winnicott, 1949).

Some have incorporated both the classical and totalistic perspectives. For example, countertransference has also been described as a concept that includes elements that influence the therapeutic relationship both positively and negatively (e.g., Blanck & Blanck, 1979; Watkins, 1985). In other words, the therapist's blind spots or unresolved issues are seen to have the potential to derail the therapeutic process if acted upon; however, countertransferential reactions can also serve as a tool for the therapist to understand the client's material (Blanck & Blanck, 1979). This view of countertransference allows for both conscious and unconscious aspects of countertransference and does not overlook the potentially detrimental aspects of countertransference behaviour. Thus, consistent with others' perspective (e.g., Peabody & Gelso, 1982; McClure & Hodge, 1987; Robbins & Jolkovski, 1987), this combined view clearly differentiates between the effects of countertransference "feelings and thoughts" and countertransference "behaviour" on the therapeutic process.

Another important distinction in the literature, perhaps first articulated by Winnicott

(1949), was between objective and subjective countertransference (e.g., Kiesler, 2000; Wilson & Lindy, 1994). Wilson and Lindy (1994) used the terms subjective and objective countertransference to differentiate between reactions on the part of the therapist that "originate from the therapist's personal conflicts, idiosyncrasies, or unresolved issues from life course development" (p. 16) with those that are more universal, or objective, in that most therapists would respond to the client's material in a similar manner.

Gelso and Carter (1985, 1994) have argued that where the classical conceptualization of countertransference was too restrictive, the totalistic perspective was too broad. Gelso and Carter (1985) differentiate between reality-based and irrational aspects of the counsellor's response to the client: the former refers to the therapist's response to the client based on the client's material, whereas the latter refers to the therapist's response to the client based on the therapist's own unresolved issues. Gelso and Carter (1994) defined countertransference as "the therapist's transference to the client's material, both to the transference and nontransference communications presented by the client (p.297).

Statement of the Problem

Although definitions and conceptualizations of countertransference have evolved over the years, and continue to be debated, current knowledge of countertransference is based primarily on clinical writings and analogue research (Hayes, McCracken, McClanahan, Hill, Harp, & Carozzoni,1998). Unfortunately, attempts to measure countertransference have been mostly superficial to date (e.g., Hayes, McCraken, McClanahan, Hill, Harp, & Carazzoni; 1998; Singer & Luborsky, 1977).With few exceptions (e.g., Cutler, 1958; McClure & Hodge, 1987; Rosenberger & Hayes, 1998), there have been no attempts to study countertransference, particularly countertransference behaviour, in a naturalistic setting. Of this research in naturalistic settings, no attempts have been made to address the issue of construct validity when assessing countertransference.

Gelso, Fassinger, Gomez, and Latts (1995) noted that empirical research has fallen behind clinical theory on countertransference:

> A key impediment to such research revolves around how to operationalize a highly abstract and global construct, such as countertransference. In attempting to simplify this construct for the sake of measurement, researchers have tended to pick up on only one or another aspect of the global construct. What has been needed is an

> operationalization of countertransference that reflects its complex and multidimensional nature. (p. 356)

Empirical research has attempted to measure countertransference in a variety of ways: by measuring the therapist's misperception of the client (e.g., Cutler, 1958; Fiedler, 1951; McClure & Hodge, 1987; Snyder & Snyder, 1961); by measuring the influence of anxiety on the therapeutic relationship (e.g., Bandura, 1956); by observing the therapist's approach-avoidance reactions in regards to various client presentations, such as hostility (Bandura, Lipsher, & Miller, 1960; Latts & Gelso, 1995; Rosenberger & Hayes, 1998); by the therapist's withdrawal of personal involvement in therapy by excluding him or herself from interpretations to the client (e.g., Peabody & Gelso, 1982; Robbins & Jolkovski, 1987; Yulis & Kiesler, 1968); by the therapist's mental activity (e.g., Dubé & Normandin, 1999); and by the therapist's deviations from his or her typical style (e.g., Holmqvist, 2001).

More recently, Hayes, McCraken, McClanahan, Hill, Harp, and Carazzoni (1998) qualitatively analyzed data from interviews with therapists immediately following their counselling sessions to gain their perspectives on countertransference. They presented a preliminary theory of countertransference that included various dimensions of countertransference called origins, triggers, and manifestations. Countertransference origins were defined as areas of unresolved intrapsychic conflict for the therapist which may serve as "blind spots" for the therapist that can impact the therapeutic relationship if triggered. Countertransference triggers included therapy events that evoked the therapist's unresolved issues. Frequently researched triggers include the clients' presenting problems, and their presentation style. Countertransference manifestations included therapists' behaviours, thoughts, or feelings that stemmed from the triggering of their unresolved issues. Consistent with others' conceptualizations of countertransference behaviour (e.g., Friedman & Gelso, 2000; Wilson & Lindy, 1994); Hayes et al.'s (1998) qualitative analysis of counsellors' interviews identified both the therapists' over-identification or over-involvement with the client, as well as their avoidance or under-involvement with the client as aspects of countertransference.

Hayes et al.'s (1998) preliminary theory seems helpful in conceptualizing the domains of countertransference (origins, triggers, and manifestations) in a manner that can be empirically validated. The authors suggested that empirical research should work backward

to first try to identify countertransference manifestations, then proceed to identify triggers and origins within the therapist. Until countertransference manifestations can be reliably and validly identified during therapy sessions, research projects investigating the relationship between countertransference and other variables, such as the therapeutic alliance or treatment outcome, will be built on a foundation of sand.

Purpose

The purpose of this exploratory research is to attempt to identify behavioural manifestations of therapist countertransference reactions during actual counselling sessions in a reliable and valid manner. Specifically, this study will address the following research questions:

1. Can countertransference behavioural manifestations, defined as therapist over-involvement and under-involvement, be reliably identified during counselling sessions with clients?
2. Is there evidence to support the contention that counsellor over-involvement and under-involvement are valid indicators of countertransference behaviour.

This study focused on behavioural manifestations of countertransference for two reasons: first, behaviour was external to the therapist, hence facilitating observation, and second, it has been identified as the aspect of countertransference that is more problematic to the therapeutic relationship. Operationalizing countertransference behavioural manifestations as over-involvement and under-involvement (Friedman & Gelso, 2000) was thought to have both clinical and empirical value. Previous research focused solely on therapists' avoidance behaviour (e.g., Rosenberger & Hayes, 1998) and overlooked negative aspects of therapists' seemingly facilitative behaviours, such as over-supporting or colluding with clients.

Design

This study employed a mixed research design to investigate countertransference manifestations. First, a multiple case study approach was selected because it was well suited for analyzing interactions intensely within naturalistic settings such as therapy sessions (e.g., Jones, 1993; Yin, 1989). In addition, generalizability theory (GT: Cronbach, Gleser, Nanda, & Rajartnam, cited in Shavelson & Webb, 1991), a statistical theory about the dependability of behavioural measurements, was also applied to help design the study (e.g., to determine the number of dyads, sessions, and judges necessary to arrive at dependable ratings of over-

involvement and under-involvement). Given that a central premise of this study weighed on establishing a dependable measure of countertransference behaviour, it seemed prudent to address this issue. Generalizability theory will be described further in the methodology section of this document.

Because feelings and thoughts are internal to the therapist, it is challenging to access those aspects of countertransference during the therapy session. The very act of asking therapists to attend to their thoughts and feelings towards the client may alter or bias their responses. In order to access the therapist's thoughts and feelings and potential countertransference triggers to support the behavioural observations, this study examined potential convergence of various sources of data (e.g., therapists' session notes, research supervisors' supervision notes, post-study ratings by counsellors and supervisors). Clinical supervision is thought to increase understanding of therapists' countertransference reactions (e.g., Singer & Luborsky, 1977); however, little existing research, if any, includes this facet in the research design. Singer and Luborsky (1977) also suggested that countertransference reactions were generally noted first by third parties (e.g., supervisors) rather than the therapist. Consequently, supervision sessions were also used to further explore the therapists' feelings and reactions to the client and the counselling sessions. The therapists' self-evaluations were requested upon completion of the therapy sessions in order to avoid biasing their behaviour during sessions.

Implications

Although the term countertransference has strong links with psychodynamic traditions in therapy, the concept has utility for therapists regardless of theoretical orientation. For example, research on the counselling relationship has acknowledged the importance of both transference and countertransference (Gelso & Carter, 1985). Unfortunately, to date, empirical research on the construct has been limited. If potential countertransference manifestations, defined as therapist over-involvement and under-involvement, can be identified by independent judges in this research study, an additional step towards construct validation will have been achieved. As a result, the relationship between countertransference origins, triggers, and manifestations can be explored further, as well as the relationship between countertransference manifestations and the therapeutic alliance and treatment outcome.

If successful, the method employed to identify countertransference manifestations may have important implications for how counselling supervision is conducted. Supervisors would be able to review a counsellor trainee's work for moments of over-involvement and under-involvement. These moments could then be explored with the trainee for possible "blind spots" or personal vulnerabilities. This exploration process could provide depth and insight to supervision and facilitate therapist development.

Chapter II

Literature Review

This section will begin with a historical overview of the evolution of the term countertransference, including more recent theoretical conceptualizations of the construct (e.g., Hayes, McCracken, McClanahan, Hill, Harp, & Carozzoni, 1998; Wilson & Lindy, 1994). Next, the clinical and empirical research on countertransference will be reviewed to summarize what has been established in the field and what remains to be explored in terms of operationalizing and measuring such an elusive construct.

The History of the Construct: Definitions and Conceptualizations of Countertransference

The definition and therapeutic usefulness of the term countertransference has evoked much debate during the 20th century. This section will outline the evolution of the construct, primarily as it has been defined in the psychodynamic literature. There are several comprehensive reviews tracing the history of the concept of countertransference (e.g., Jacobs, 1999; Singer & Luborsky, 1977; Slakter,1987). This review will highlight the most salient contributions, starting with Sigmund Freud who first coined the term in 1910, and continuing with more recent theoretical models of countertransference.

Classical perspective. According to Freud (1910) and many of his followers, countertransference is the analyst's unconscious response to the patient's transference, and if unrecognized by the analyst and uncontrolled, this response can have an adverse effect on the therapeutic process by interfering with the analyst's ability to understand his or her patient. Thus, all attempts must be made by the analyst to minimize the effects of countertransference. This definition describes the classical psychoanalytical view of countertransference.

Anne Reich (1951, 1960) wrote two notable papers supporting the classical position. In her first paper she stated that countertransference, "comprises the effects of the analyst's own unconscious needs and conflicts on his understanding or technique" (1951, p. 26). She distinguished between acute manifestations of countertransference, which occurred suddenly under specific circumstances with specific clients, and permanent or chronic manifestations of countertransference, which reflected more habitual neurotic difficulties of the therapist that could arise in a variety of situations across different clients.

Reich's (1960) second paper on countertransference attempted to refute the notion

that countertransference was a useful force within the therapeutic process. She argued that this idea was a result of a failure to differentiate between the therapist's countertransference, which is generally unconscious, and his or her total response, which includes conscious responses. Reich (1960) stressed that "conscious responses should be regarded as countertransference only if they reach an inordinate intensity or are strongly tainted by inappropriate sexual or aggressive feelings, thus revealing themselves to be determined by unconscious infantile strivings" (p. 390).

Ferenczi (cited in Jacobs, 1999), a follower of Freud, disagreed with his mentor's perspective on countertransference. He pointed out that the analyst's reactions to his or her clients were an essential ingredient to empathic understanding. Although highly criticized, Ferenczi was interested in the "role of metacommunications in analysis and of the interplay between the minds of patient and analyst," a view "that was quite remarkable for its time." (Jacobs, 1999, p. 578). Perhaps, Ferenczi's queries paved the way for what later came to be known as the "totalistic perspective" on countertransference.

Totalistic perspective. Roughly thirty years after Ferenczi's questioning of Freud's views, others challenged the classical position that countertransference reactions were primarily unconscious and detrimental to the therapeutic process (e.g., Heimann, 1950; Kernberg, 1965; Little, 1951; Winnicott, 1949). This view, labelled the "totalistic" perspective, defined countertransference more broadly to include all feelings and thoughts a therapist holds in response to a client. In this view, the therapist's reactions are thought to increase his or her understanding of the client and facilitate the empathic process.

According to Heimann (1950), in order to achieve an empathic understanding of the client's experience and internal world, the therapist engages in a trial identification with the client in order to arouse feelings within him or herself that shed light on the client's material. Thus, in order to respond empathically to clients, the therapist must be able to first feel what the client is feeling (e.g., harness his or her countertransferential feelings).

In his classic paper, "Hate in the Countertransference," Winnicott (1949) differentiated between objective countertransference reactions within the therapist (which are based on the client's actual personality) from those countertransference reactions that are more subjective in nature (based on the therapist's personal experiences and development). Winnicott argued

that severely disturbed clients could evoke intense countertransference reactions of hate within the therapist. These reactions were to be understood by the therapist so that he or she did not act out during the therapy hour to the detriment of the client.

Winnicott (1949) was perhaps the first to distinguish between objective and subjective countertransference. Other writers have since adopted this distinction (e.g., Kiesler, 2001; Wilson & Lindy, 1994). In his review of the literature, Kiesler (2001) adapting Winnicott's definition, described objective countertransference as "the constricted feelings, attitudes, and reactions of a therapist that are evoked primarily by the client's maladaptive behaviour and that are generalizable to other therapists and to other significant persons in the client's life" (p.1057). Kiesler described subjective countertransference as "the defensive and irrational reactions and feelings a therapist experiences with a particular client that represent residual effects of the therapist's own unresolved conflicts and anxieties" (p. 1057). Similarly, Wilson and Lindy's (1994) theoretical model, described below, differentiated between objective and subjective countertransference.

Bouchard, Normandin, and Sequin (1995) distinguished between three types of countertransference: rational-objective countertransference, reactive countertransference, and reflective countertransference. Whereas the first two types correspond to the definitions of objective and subjective countertransference noted above, the latter is consistent with definitions of empathy. The authors developed the Countertransference Rating System (CRS) to measure therapists' mental activity along these dimensions. (This research is described later in this document under the section titled empirical research).

Over the years countertransference has come to be viewed by many to include elements that influence the therapeutic relationship both positively and negatively (e.g., Blanck & Blanck, 1979; Watkins, 1985). If acted upon, the therapist's blind spots or unresolved issues may interfere with the therapeutic process. However, if analyzed and understood, the therapist may also use his or her countertransferential feelings as a tool to understand the client's material (Blanck & Blanck, 1979). This view of countertransference allows for both conscious and unconscious aspects of countertransference and does not overlook the potentially detrimental aspects of countertransference behaviour.

Where the supporters of the totalistic perspective have argued that the classical

conceptualization of countertransference was too restrictive, others have argued that the totalistic perspective was too broad (e.g., Gelso and Carter 1985, 1994; Gelso & Hayes, 1998, 2002a, 2002b). Gelso and Carter (1985) differentiated between reality-based and irrational aspects of the counsellor's response to the client: the former refers to the therapist's response to the client based on the client's material, whereas the latter refers to the therapist's response to the client based on the therapist's own unresolved issues. Gelso and Carter (1994) defined countertransference as "the therapist's transference to the client's material, both to the transference and non-transference communications presented by the client (p.297). This definition is more closely aligned with the description of subjective countertransference, locating the origins of the therapist's conflictual reactions in his or her unresolved intrapsychic issues.

Most writers in the area of countertransference further differentiate between countertransference feelings and behaviours (e.g., McClure & Hodge, 1987; Peabody & Gelso, 1982; Robbins & Jolkovski, 1987). Countertransference feelings can take various forms such as feeling affectionate, nurturant, sexually aroused, pity, frustration, annoyance, and hostility (Snyder & Snyder, 1961). Countertransference behaviour can include acting overly solicitous, seductive, withdrawn, or punitive towards clients. It is generally agreed that acting out countertransference behaviour leads to poor counselling outcomes (e.g., Gelso & Carter, 1985). Similarly, most clinicians and researchers agree that therapists must strive to bring their reactions to clients into awareness so that they can be understood and managed (e.g., Hayes, Riker, & Ingram 1997; Singer & Luborsky, 1977) or even employed therapeutically (e.g., Blanck & Blanck, 1979, Winnicott, 1949).

Theoretical models. Theoretical models have also been developed to shed light on this complex construct. Wilson and Lindy (1994) presented a model to study therapists' empathic difficulties and countertransference reactions with clients who experienced post-traumatic stress. Although their model was originally constructed to depict the experience of therapists who work in the field of trauma, the authors acknowledge its usefulness with other client populations. The four quadrants of the model are depicted in Figure 1.

Extending the work of others (e.g., Lindy, 1988; Maroda, 1991; Slatker, 1987; and Wilson, 1989), Wilson and Lindy (1994) differentiated between two categories of

countertransference reactions, Type I (avoidance) and Type II (over-identification). Type I reactions include forms of denial, minimization, distortions, avoidance, detachment, and withdrawal, whereas Type II reactions involve forms of over-identification, over-idealization, enmeshment, and excessive advocacy for the client. Both types of countertransference reactions result in a movement away from an empathic stance by the therapist. The authors note that therapists may experience one style more than another (e.g., over-identification versus avoidance.)

Wilson and Lindy's (1994) model also differentiated between objective and subjective countertransference, along with four types of empathic strain that relate to the different types of countertransference reactions. The authors referred to subjective and objective countertransference to differentiate between reactions on the part of the therapist that "originate from the therapist's personal conflicts, idiosyncrasies, or unresolved issues from life

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Figure 1. Modes of Empathic Strain in Countertransference Reactions (CTRs)
(Wilson & Lindy, 1994)

OBJECTIVE COUNTERTRANSFERENCE

Empathic Disequilibrium	Empathic Withdrawal
uncertainty	blank screen facade
vulnerability	intellectualization
unmodulated affect	misperception of dynamics
Type II Countertransference	Type I Countertransference

Over-identification	Avoidance
Empathic Enmeshment	Empathic Repression
loss of boundaries	withdrawal
over-involvement	denial
reciprocal dependency	distancing

SUBJECTIVE COUNTERTRANSFERENCE

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course development" (p. 16), with those that are more universal, or objective, in that most therapists would respond to the client's material in a similar manner. This distinction between objective and subjective countertransference is similar to that made by Winnicott (1949).

More recently, Hayes, McCracken, McClanahan, Hill, Harp, and Carozzoni (1998) developed a preliminary theory based on a qualitative analysis of data from interviews with eight psychologists (four men and four women), immediately following their counselling sessions to gain their perspectives on countertransference. Therapy sessions ranged between 12-20 session, for a total of 127 sessions. Post-session interviews with the psychologists were conducted to gather information about their impressions and reactions regarding the session. The researchers analyzed the 127 post-session interviews to identify sections pertaining to countertransference. Sections of the interviews were considered to depict countertransference reactions only if the therapists self-identified their reactions as deriving from unresolved intrapsychic conflict. From this data, Hayes et al. (1998) presented a preliminary theory of countertransference which included various dimensions of countertransference called origins, triggers, and manifestations.

Countertransference origins were defined as areas of unresolved intrapsychic conflict for the therapist that may serve as "blind spots" for the therapist and which can impact the therapeutic relationship if triggered. Examples of origins include: family issues, therapist's needs and values, therapy issues such as termination, and cultural issues. Countertransference triggers were defined as therapy events that evoke the therapist's unresolved issues. Examples of triggers include: the content of the client's material (e.g., death, family of origin), changes in the therapy structure, therapist's perception of the client (e.g., as dependent or hostile), and the client expressing negative emotion. Countertransference manifestations were described as therapist's behaviours, thoughts, or feelings that are a consequence of unresolved issues being triggered. Examples of manifestations include: "approach" responses by the therapist (e.g., nurturing, identification, positive feelings towards the client), "avoidance" responses by the therapist (e.g., distancing self from the client, boredom or fatigue, disappointment with the client), and negative feelings by the therapist.

Hayes, McCracken, McClanahan, Hill, Harp, and Carozzoni's (1998) preliminary theory seems helpful in conceptualizing the domains of countertransference (origins, triggers,

and manifestations) in a manner that can be empirically validated. Their conceptualization of countertransference manifestations includes both approach and avoidance responses by the therapist, which is consistent with others' formulations (e.g., Friedman and Gelso, 2000; Wilson and Lindy, 1994). Unlike previous definitions of therapist "approach" responses as facilitative of the therapeutic process, in this context "approach" responses refer to those responses by the therapist that are seemingly helpful, such as over-supporting, but can serve to de-rail the process. Based on others difficulty predicting countertransference behaviour from potential countertransference origins (i.e., Rosenberger & Hayes, 1998), the authors suggested that empirical research should work backwards to first try to identify countertransference manifestations, then proceed to identify triggers and origins within the therapist.

To summarize, this section briefly outlined the evolution of the construct of countertransference from Freud's (1910) early writings, to more recent conceptualizations. Depending on which definition is applied, the impact of countertransference reactions on the therapeutic process can be viewed as negative, positive, or both. The differing definitions of countertransference have led to varying opinions about how it relates to the empathic process. As noted previously, Heimann (1950), one of the earliest writers on the "positive" view of countertransference, described using the therapist's emotional responses, or countertransferential feelings, as the basis to formulate empathic responses. Reich (1960) believed that the therapist's empathic failure in the trial identification with the client is the result of his or her countertransference. In other words, breaches in the empathic process or a movement away from an empathic stance by the therapist, are due to the therapist's countertransference reactions.

Consistent with the "totalistic" view of countertransference, this researcher believes that countertransference reactions can have both a positive and negative impact on the therapeutic process. In addition, there can be both conscious and unconscious aspects of countertransference which relate to either the client's material (e.g., objective countertransference) or the therapist's unresolved intrapsychic conflicts (e.g., subjective countertransference). Countertransference "feelings" can help deepen the therapist's understanding of the client's experience; however, countertransference "behaviour" can

interfere with the therapeutic process and lead to empathic failures. This notion of empathic breaches as a possible indicator that the therapist's countertransference reactions are being aroused has implications for observing countertransference reactions during counselling sessions.

Clinical Research on Countertransference

The vast clinical literature on countertransference spans over 80 years and includes mostly anecdotal reports in psychoanalytic journals. According to these reports, countertransference feelings towards clients can take various forms such as feeling affectionate, nurturant, sexually aroused, pity, frustration, annoyance, and hostility (e.g., Snyder & Snyder, 1961). As a result, therapists may find themselves having dreams about their clients, or behaving in an overly solicitous, supportive, or punitive manner towards them. It was generally thought that countertransference behaviour, not feelings, negatively impacted the therapy process (e.g., Gelso & Carter, 1985).

In their review of this clinical literature, Singer and Luborsky (1977) noted that the findings from the extensive number of anecdotal reports were varied and complex. They summarized the following points: first, countertransference could impede effective treatment because it interfered with the therapist's ability to form a proper identification with the client. Identification was thought to be a necessary part of the process of understanding. Second, a sign that countertransference was in operation was if the therapist had intense sexual or aggressive feelings towards the client. Third, countertransference could be one of two types: it may arise in response to specific situations and specific clients (acute); or it may occur across clients and conflicts, reflecting a habitual need of the therapist (chronic). Fourth, the more general definition of countertransference (totalistic perspective) may be an effective therapeutic tool to assist therapists in empathizing with clients. Five, all authors emphasized the importance of having countertransference reactions under conscious awareness and control to minimize their detrimental effects on the therapeutic process. Six, the therapist's emotional maturity and self-understanding, usually gained through personal psychotherapy or psychoanalysis, helped to minimize the enactment of countertransference needs. Seven, countertransference feelings and behaviour could be managed through self-analysis or by consulting with a supervisor or colleague. Finally, countertransference may be observed

through peripheral cues such as body movement or changes in the tone of the therapist's voice.

Current reviews of the clinical literature (e.g., Hinshelwood, 1999; Jacobs, 1999; and Kernberg, 1999) articulated similar themes to those summarized by Singer and Luborsky (1977) twenty five years ago. It seems that theoretical discussions and anecdotal reports continue to be the favoured method of presenting countertransference reactions in psychoanalytic journals. Recently, Kiesler (2001) questioned whether we can "anchor our divergent constructs of CT in agreed upon actual therapist behaviours?" (p.1058). He proposed that counsellors' "deviations from baselines" could be a possible method to detect both subjective and objective countertransference during therapy sessions. In other words, subjective countertransference may be in operation when the therapist's reactions to a particular client deviate noticeably from his or her usual response (baseline) with the same client or with other clients; objective countertransference may be in operation when the therapist's reactions to the client, or deviations from baseline, are similar to those of the therapist's colleagues and significant others in the client's life. Prior assessment of the therapist, his or her colleagues, clients, and the clients' significant others would be necessary to accumulate baseline data. This suggestion holds promise for stimulating research on how to operationalize and measure countertransference behaviour.

Empirical Research on Countertransference

Several attempts have been made to study countertransference empirically using a variety of methods. The following section will review these studies according to their conceptualization of countertransference as, 1) perceptual distortion; 2) mental activity; 3) withdrawal of personal involvement or avoidance reactions; 4) over-involvement and/or under-involvement; and 5) deviations from baseline.

Countertransference as perceptual distortion. In an exploratory study, Fiedler (1951) attempted to measure therapist distortions using a Q-sort technique. Distortions in the therapists' sorts were deemed to indicate the presence of countertransference (i.e., the amount to which the therapist over or underestimated the client's similarity to himself or the client's similarity to the therapist's ideal). Unfortunately the results were inconclusive, primarily due to small sample size and methodological problems. However, Fiedler's attempt to quantify

countertransference influenced future research on the topic (McClure & Hodge, 1987).

A classic study by Cutler (1958) operationalized countertransference according to Brunner's (cited in Cutler, 1958) theory of perception which notes that, "strong need-satisfying hypotheses will tend to be confirmed on the basis of minimal appropriate information from the environment" (p. 350). The author questioned whether countertransference may be a special case of perception being influenced by need. Two therapists and five clients participated: therapist one saw three clients across three consecutive sessions and therapist two saw two clients across four consecutive sessions. A self-report measure was used to collect data on the therapists' conflictual areas. Cutler (1958) concluded that the therapists were less accurate in reporting material about a client whose needs directly related to needs identified in the therapists' own personalities.

As part of an in-depth study on the psychotherapy relationship, Snyder and Snyder (1961) collected extensive data on one therapist and several of his clients. The authors developed an affect scale to measure both the therapist's and the clients' emotional reactions during the session. After each therapy session, the therapist and the clients would complete the measure. In addition, the therapist would fill out the affect scale according to how he believed the clients responded. The difference between each client's actual score and the therapist's perception of his or her ratings was viewed as the therapist's perceptual distortion and was considered an index of countertransference. The authors found that more negative countertransference effects occurred with clients that had less successful therapy outcomes. Also, there was a trend for countertransference to increase as sessions continued.

McClure and Hodge (1987) explored the relationship between the therapist's attitude of liking or disliking his or her client and countertransference. Countertransference was operationalized as "the difference between the therapist's perception of the client's personality and the client's own perception" as measured by the Taylor-Johnson Temperament Analysis (TIJA; Nash, cited in McClure & Hodge, 1987). Ten doctoral level therapists affiliated with a university counselling centre, two established therapists in private practice, and their 28 clients living in Southern California participated in the study. The authors noted that the TIJA was developed to assess the personality configuration of either an individual client, a couple, or a family, as well as measure one person's view of another. The therapists completed the TIJA

for themselves and for each of their clients. The clients also completed the measure for themselves. An attitude scale embedded within the TIJA was used to assess therapists' attitudes towards their clients (positive, neutral, or negative).

The authors found that, for cases in which the therapists held a positive attitude toward the client, they distorted the client's personality in such a way as to make it more similar to their own personality profile. For cases in which the therapists indicated a negative attitude towards the client, they distorted the client's personality to be more dissimilar than their own. For cases in which the therapists held a neutral or intermediate attitude towards the client, the therapists did not distort the client's personality to be more or less similar than their own profiles. The authors argued that the distortions in the therapists' ratings were evidence of the presence of countertransference.

Countertransference as therapist's mental activity. As described earlier, Bouchard, Normandin, and Seguin (1995) distinguished between three types of countertransference: rational-objective countertransference, reactive countertransference, and reflective countertransference. The first type referred to mental activity by the therapist that was detached, observing rather than participating; the second type referred to mental activity by the therapist that was defensive, consistent with the classical definition of countertransference; and, the third type referred to mental activity by the therapist that was consistent with an engaged, empathic stance. The authors developed the Countertransference Rating System (CRS) to measure therapists' mental activity along these dimensions.

Recently, Dubé and Normandin (1999) applied the CRS to investigate 27 trainee therapists' spontaneous reactions to five clinical vignettes depicting actual client-therapist interactions. The researchers explored whether trainees' personal psychotherapy impacted their listening process (mental activity). After reading each vignette, the trainees were instructed to record their reactions to what was occurring in the vignette. Judges scored the trainees' responses to the vignettes using the CRS. Agreement between the judges was moderately good for the three types of mental activity (rational-objective $k = .52$; reactive $k = .60$; and reflective $k = .63$). The researchers found that the reflective category, with its various subcategories, was the most frequently observed type of mental activity. Trainees who had had their own personal therapy were less likely to block out or act on their reactions

compared with those who had not had personal therapy. In addition, those who had experienced their own therapy tended to elaborate the client's internal world more extensively than did the "no therapy" group. Personal therapy was found to have no effect on rational-objective or reactive countertransference. The authors noted that they continue to refine the CRS for research purposes and hope to develop distinct scores for each mental activity to allow profile analyses.

Countertransference as withdrawal of personal involvement or avoidance. Yulis and Kiesler (1968) characterized countertransference as therapist withdrawal of involvement. They developed a procedure to assess countertransference behaviour in response to three stimulus tapes of an actress portraying a client who presented as sexual, hostile, and neutral (in terms of the sexual and hostile portrayals). Each 15 minute tape consisted of 10 segments, allowing for therapist interventions at each stopping point. After each segment, participants were instructed to choose between two written responses: both responses were deemed therapeutically appropriate by expert judges but differed in terms of degree of personal involvement. Hence, counsellor involvement or withdrawal was determined by his or her selection of intervention responses. Consistently selecting responses that excluded personal involvement was viewed as countertransferential behaviour. The authors supported their prediction that participants with low anxiety scores would be more personally involved (i.e., show less countertransference) with their clients than participants with high anxiety scores. However, they did not find that participants showed less countertransference with the neutral tape scenario versus the sexual and hostile scenario.

Using Yulis and Kiesler's (1968) procedure to investigate countertransference, Peabody and Gelso (1982) studied the complex relationship between counsellor empathy, awareness, and amount of countertransference behaviour. Twenty-two male doctoral students in counselling psychology participated in the study. Overall, the authors found that empathy was negatively related to countertransference behaviour in the sexual analog scenario, but not in the other two scenarios. In addition, counsellor empathic ability was positively related to counsellor reports of openness to countertransference feelings.

Countertransference reactions by the therapist have often been operationalized as "avoidance reactions." In general, avoidance reactions refer to those responses by the

therapist that are designed to inhibit further exploration of a topic (e.g.. disapproval, changing topics, silence), whereas approach reactions refer to those responses by the therapist that are designed to facilitate further exploration of a topic (e.g., reflection, approval, instigation) (e.g., Bandura, Lipsher, & Miller, 1960; Latts & Gelso, 1995).

Bandura, Lipsher, and Miller, (1960), investigated therapists' countertransference, operationalized as avoidance reactions, to clients' expressions of hostility. They investigated three hypotheses: 1) that therapists who experienced high anxiety around client hostility would exhibit avoidance behaviour, (rather than encouragement or approach behaviour) compared to therapists who experienced low hostility anxiety; 2) that patients would be encouraged to express further hostility if the therapist responded with approach versus avoidance reactions; and 3) that if the therapists responded with an avoidance versus an approach response to the client's expression of hostility, the client would be more likely to change the object of their hostility.

The authors analyzed tape recordings from 110 therapy sessions obtained from 17 clients and 12 therapists. The counsellors' responses were coded for approach and avoidance reactions by two judges. Inter-judge reliability for the counsellor's approach and avoidance responses was assessed by the degree of agreement between the two judges in coding the response units. Two hundred and sixty one of the response units scored were in perfect agreement; 100 units showed minor discrepancies, mainly due to some overlap in the categories that were coded; and 37 units were rated in the opposite direction by the judges (e.g., one judge rated the unit as an avoidance response and the other rated as an approach response).

Clinical psychology staff rated the therapists' personality characteristics. The interactions between therapists and their clients were coded for the following elements: 1) the number of times the therapists responded with approach or avoidance responses to the clients' expression of hostility; 2) the frequency with which clients continued to express hostility immediately following therapists' approach or avoidance responses; and 3) the objects towards whom the clients expressed their hostility.

Although the authors did not confirm their first two hypotheses, they did find support for their third hypothesis. In addition, they found that: 1) therapists who had a low need for

approval and who expressed their own hostility directly were more likely to encourage their clients' expression of hostility compared with therapists who had a high need for approval and who expressed their hostility indirectly; and, 2) therapists were more likely to avoid clients' hostility when it was directed towards them versus other objects. This research also provided a useful operationalization of countertransference as "therapist avoidance reactions" that has been adopted and expanded by others (e.g., Friedman & Gelso, 2000; Gelso, Fassinger, Gomez, & Latts, 1995; Hayes & Gelso, 1993; Rosenberger & Hayes, 1998; Yulis & Kiesler, 1968).

Hayes and Gelso (1993) studied 34 male counsellors' reactions to gay and HIV positive clients using an analogue research design. The independent variables included client sexual orientation and HIV status; the dependent variable was counsellor discomfort, assessed using affective, cognitive, and behavioural measures. The affective component was defined as counsellor state anxiety using a self-report measure; the cognitive component was defined as counsellor inaccuracy in recalling client material (number of words related to sexuality or death); and the behavioral component was defined as counsellor approach-avoidance responses based on their verbal responses to the videotaped clients. Counsellors' responses were coded as approach, avoidance, or neither by three judges. Interrater reliability for the proportion of ratings on which pairs of judges agreed were .67, .69, and .73. A cumulative ratio of the number of avoidance responses to the number of approach and avoidance responses was calculated. In addition, counsellor's degree of homophobia and death anxiety was assessed using self-report measures. Two young male actors played the four client scenarios: HIV-positive/gay; HIV-negative/gay; HIV-positive/ heterosexual; and HIV-negative/heterosexual.

The counsellors were randomly assigned to the eight scenarios (2 actors X 4 conditions). Each video-tape had five pre-designated places where the tape stopped and the counsellor could record his or her response into a microphone. The researchers found that there was no difference between counsellors' discomfort with gay versus heterosexual clients (no main effect for sexual orientation). The interaction between HIV status and sexual orientation was also not significant. As hypothesized, counsellors' higher ratings on the homophobia measure predicted their discomfort with gay male clients, and counsellors

reported greater discomfort with HIV-positive versus HIV-negative male clients. The researchers did not support their hypothesis that higher scores on the death anxiety measure would predict counsellors' discomfort with HIV-positive clients better than their discomfort with HIV-negative clients.

Gelso, Fassinger, Gomez, and Latts (1995) were interested in the role of homophobia, counselor gender, and countertransference management on countertransference reactions to lesbian clients. Once again, an analog research design was employed with 68 masters and doctoral students in counselling programs observing a video tape simulation of a client and completing various self-report inventories to measure the constructs of interest. A similar procedure employed by other researchers (e.g., Hayes & Gelso, 1993; Latts & Gelso, 1995) was also used in this study. Counsellors were randomly assigned to one of the two sexual orientation scripts. Each tape contained eight segments; after each segment participants could verbally respond into a microphone as they would in an actual therapy session. Countertransference behaviour was defined as the ratio of avoidance responses to the sum of approach and avoidance behaviours in the counsellor's verbal responses. As predicted, the researchers found that the higher the level of homophobia, the greater the counsellors' avoidance response to the client's material.

A large scale study on psychotherapy (The Menninger Foundation's Psychotherapy Project, cited in Singer & Luborsky, 1977), attempted a retrospective study of countertransference that had occurred within the context of actual therapy sessions. After treatment had ended, the researchers tried to reconstruct the influence of countertransference by reviewing various sources of information, such as post-treatment interviews with the client, the therapist, and supervisor, and the complete process notes. The researchers found it difficult to determine the influence of countertransference.

Applying the tentative theory of countertransference origins, triggers, and manifestations outlined by Hayes et al. (1998), Rosenberger and Hayes (1998) attempted to investigate the relationships among the origins of countertransference, client verbalizations thought to trigger countertransference behaviour, manifestations of countertransference behaviour, and the effects of countertransference behaviours on the client's and therapist's perceptions of session depth and smoothness. They employed an intensive case study design,

following one counsellor-client dyad across 12 counselling sessions. The client and the counsellor were both white males. The client was 20 years old and the therapist was 32 years old.

Rosenberger and Hayes (1998) attempted to identify the therapist's countertransference origins (e.g., unresolved intrapsychic conflicts) by having the therapist and three people who knew the therapist well complete the Adjective Check List (ACL; Gough & Heilbrun, cited in Rosenberger & Hayes, 1998). Countertransference origins, or "blind spots," for the therapist were identified by the scales on which therapist and cohort T-scores differed by 10 points. The researchers also tried to identify countertransference origins by conducting a pre-treatment interview with the therapist to ask him "to identify and discuss themes which might tap into resolved and unresolved intrapsychic conflicts." (Rosenberger & Hayes, 1998, p. 11). A total of 10 themes emerged from the ACL (three) and the interview (seven).

Countertransference triggers were identified by having three trained raters view the therapy sessions and code the content of each client talking turn based on the 10 countertransference origins. An additional category called "other" was also included to code the talking turns. The inter-rater reliability for the three raters was .67, with individual pairs of raters ranging form .61 to .76. (The researchers did not specify whether these numbers indicate reliability coefficients or percent agreement for raters).

Rosenberger and Hayes (1998) identified manifestations of countertransference behaviour in the following manner: first, countertransference behaviours were assessed for every speaking turn by rating approach and avoidance responses. This technique was similar to the one developed by Bandura et al. (1960) and used in previous analogue research on countertransference. Bandura et al. (1960) defined avoidance behaviours as "those verbal responses designed to inhibit, discourage, or divert the patient's hostile expressions" (p. 3). Raters were presented with a grid, with the left column containing both approach reactions (approval, exploration, instigation, reflection, and labelling) and avoidance reactions (disapproval, topical transitions, silence, ignoring, and mislabelling), as well as a separate category for "unclassifiable responses" which represented all speaking turns which were not classified as approach or avoidance. Rater reliability for the three 10 minute training videos

was .97 for the three judges. Inter-rater agreement for the case study was not reported.

The authors also identified countertransference behaviours by session using the Inventory of Countertransference Behaviour (ICB; Friedman & Gelso, 2000). The ICB provides a global score of the therapist's countertransference behaviour, operationalized as therapist over-involvement and under-involvement, for the therapy session. A separate team of judges independently rated the 12 counselling sessions on the ICB.

Rosenberger and Hayes (1998) tested three hypotheses. Their first hypothesis was that client speaking turns containing conflictual material would tend to be followed by therapist speaking turns containing avoidance behaviour. They employed a sequential analysis technique to calculate the conditional probability of the therapist's avoidance response immediately following the client's speaking turn containing conflictual material. The results did not support the authors' hypothesis either across or within the counselling sessions.

Their second hypothesis was that there would be a positive relationship between the frequency with which the client talked about issues that were conflict-relevant for the therapist and the frequency of countertransference behaviour. This hypothesis was assessed in two ways. One, the total number of client speaking turns containing conflictual material was correlated with the total number of therapist speaking turns containing avoidant responses; and two, Pearson correlation coefficients were calculated between scores on the Inventory of Countertransference Behaviour and number of conflictual client speaking turns for each session. Both attempts to test this hypothesis were not supported. There was a trend towards a positive relationship between the Negative Countertransference factor on the ICB and the number of conflictual client speaking turns.

Rosenberger and Hayes' (1998) third hypothesis tested whether sessions with higher frequencies of therapist countertransference behaviour would be rated less favourably by the client and therapist dyad than would sessions with lower frequencies of countertransference behaviour. Again, this hypothesis was tested in two ways. One, Pearson correlation coefficients were calculated between the number of avoidant therapist speaking turns and the dyad's ratings on the Session Evaluation Questionnaire (SEQ; Stiles & Snow, cited in Rosenberger & Hayes, 1998); and two, Pearson correlation coefficients between the ICB and client and therapist ratings on the SEQ were calculated. The first test of this hypothesis was

not supported. Surprisingly, it was found that the more the therapist engaged in avoidance behaviour, the deeper he perceived the session to be. All other relationships regarding this hypothesis did not reach statistical significance, but were in the expected direction. The second test of the authors' hypothesis received some support. They found an inverse relationship between the ICB's Negative Countertransference factor, and the therapist's perceptions of the depth and smoothness of the sessions. No other significant relationships were found (e.g. Positive Countertransference factor and Total Countertransference).

Recently, Rosenberger and Hayes (2002) replicated the research methodology described above with another counsellor-client dyad across 13 therapy sessions. The counsellor was a 34 year old, White female psychologist. The client was a 21 year old, White female. The authors tested the same three hypotheses: first, that client speaking turns containing conflictual material would tend to be followed by counsellor speaking turns containing avoidance behaviour; second, that there would be a positive relationship between the frequency with which the client talked about issues that were conflict-relevant for the counsellor and the frequency of countertransference behaviour; and third, that sessions with higher frequencies of counsellor countertransference behaviour would be rated less favourably by the client and counsellor dyad than would sessions with lower frequencies of countertransference behaviour.

The authors did not support their first and second hypotheses. In fact, the test for the second hypothesis was in the opposite direction than expected; the counsellor's avoidance behaviour was inversely related to the frequency with which the client addressed conflict-relevant material. The third hypothesis received partial support. The counsellor's ratings of session depth was inversely related to the frequency with which the client addressed conflict-relevant material that the counsellor was both unaware ($r = -.31$) and aware ($r = -.48$). There was also a positive relationship between session smoothness and frequency with which the client addressed conflict-relevant material that the counsellor was unaware ($r = .51$). The client's ratings of these dimensions (e.g., session depth and smoothness) were unrelated to the counsellor's avoidance behaviour.

Rosenberger and Hayes (2002) also explored the impact of the client addressing material identified as conflictual for the counsellor on the counsellor's ratings of the working

alliance and the counsellor's social influence. The impact of the counsellor's avoidance behaviour on the client's ratings of the working alliance and the counsellor's social influence were also explored. A positive relationship was found between the counsellor's ratings of the working alliance and the frequency with which the client addressed conflict-relevant material that the counsellor was aware ($r = .47$). No other significant relationships were found for the counsellor or the client regarding the working alliance.

In terms of the counsellor's social influence, there was a negative correlation between the frequency with which the client addressed conflict-relevant material that the counsellor was aware and the counsellor's ratings of expertness ($r = -.50$) and attractiveness ($r = -.36$). There was also a negative relationship between conflictual material that the counsellor was unaware and her ratings of trustworthiness ($r = -.52$). No other significant relationships were found for the counsellor regarding this variable. Due to the lack of variability in the client's ratings, no correlations could be calculated to explore the impact of the counsellor's avoidance behaviour on the client's ratings of the counsellor's social influence.

The research by Rosenberger and Hayes (1998; 2002) was innovative and served to highlight the challenges of studying countertransference in a naturalistic setting. It may have been ambitious to attempt to predict countertransference behaviour from predetermined countertransference origins, given the difficulty at ascertaining valid measures of "therapists' unresolved intrapsychic conflicts." Also, conducting a pre-treatment interview with the therapist to identify countertransference origins could have unknowingly biased the results. To avoid some of these methodological challenges, Hayes et al. (1998) suggested "working backwards" to try to identify countertransference manifestations first, then triggers, and then origins.

Countertransference as over-involvement and under-involvement. The Inventory of Countertransference Behaviour (ICB; Friedman & Gelso, 2000) was recently developed to measure two dimensions of countertransference: therapist over-involvement and under-involvement. This conceptualization of countertransference is consistent with Wilson and Lindy's (1994) model of countertransference described earlier (e.g., describes countertransference as either the therapist's over-identification with or avoidance of the client's material). The ICB originally contained 32 items on which supervisors or judges could

rate the extent to which a therapist-trainee's behaviour in a session reflected specific manifestations of countertransference. Respondents rated the trainee's reaction to a particular client in a given session on a five-point Likert type scale, where 1 = to a little or no extent and 5 = to a great extent. The instrument was designed with a stem ("The counsellor") followed by 32 stem endings. The items were hypothesized to represent behaviours that reflected both over-involvement and under-involvement by the counsellor.

Exploratory factor analysis was conducted as part of the development process. This analysis suggested that the two subscales that emerged from the analysis were not indicative of the hypothesized dimensions, but rather described: 1) inappropriate therapist behaviours that were disapproving of clients (titled Negative Countertransference - 11 items), and 2) inappropriate therapist behaviours that were overly familiar or supportive (titled Positive Countertransference - 10 items). A total score was calculated for the ICB, with higher totals indicating increased levels of countertransference behaviour. Thus, the ICB provided a global score of countertransference behaviour for the therapy session. Individual scale scores can also be calculated.

Counsellor over-involvement, or positive countertransference, included items such as: seemed to agree too often with the client, over-supported the client, befriended the client, frequently changed the topic, talked too much, acted in a submissive way. Counsellor under-involvement, or negative countertransference, included items such as: treated client in a punitive manner, was critical of the client, spent time complaining, provided too much structure, inappropriately questioned the client's motives.

The authors acknowledged that operationalizing countertransference behaviour as therapist over-involvement and under-involvement (which they renamed positive and negative countertransference after factor analysis) did not capture the complete complexity of the phenomena. However, it did attempt to include overt behaviours that were more likely to be observed when assessing actual counselling sessions. To date, Rosenberger and Hayes' (1998) case study described above was the only research that has employed the ICB as a global measure of countertransference. However, they relied on the "avoidance" definition of countertransference when analyzing the therapist's behaviour more closely within sessions.

Countertransference as deviations from baseline. A recent study investigated patterns

of consistency and deviation in therapists' feelings across clients (Holmqvist, 2001). Nine therapists and 28 clients participated in the study. The number of clients a therapists worked with ranged from one to six. Therapy sessions ranged from nine to 88. The therapists reported their feelings after each therapy session using a feeling checklist. The author attempted to identify four deviating reactions in the therapists: 1) therapist-characteristic countertransference (therapists' habitual feelings that differed from other therapists' habitual feelings); 2) patient-characteristic countertransference (therapists' feelings over a whole therapy with one patient that differed compared to their feelings over a whole therapy with other patients; 3) session-characteristic countertransference with respect to the therapist (therapists' feelings in individual sessions that differed from their usual response style across patients; and 4) session-characteristic countertransference with respect to the client (therapists' feelings in individual sessions that differed from their usual response style with that specific patient).

The author used analysis of variance to investigate differences in reactions between therapists generally, and between feelings toward individual patients. Discriminant analysis was used to discriminate the therapists by the feelings they reported, and to discriminate the therapies for individual clients by the feelings that were reported from them. The results suggested that therapists were consistent in their feeling style across time. In other words, which therapist had produced which feeling checklist could be predicted accurately most of the time. The therapists' reactions were less consistent towards individual patients. The therapists' deviations from their usual responses were thought to be possible examples of countertransference reactions. Holmqvist (2001) stated:

> deviating tendencies or deviating reactions in individual sessions could be regarded as indicators of important processes in the therapy. The statistical method does not give any information about the reason for the deviating reactions. What the method does achieve is to point out those reactions that deviate from the therapist's normal reaction pattern. The discriminant analysis does this without relying on the therapist to report that the reaction is unusual. In this way, it was possible to bypass one of the problems in studying countertransference. The therapist's consciousness of countertransference reactions as

> clinically described may vary, and methods of mapping countertransference that presuppose that the therapist reports the reaction as unusual may consequently be less apt. With the method presented here, this question is irrelevant. (p. 114)

Because the data violated various assumptions for the statistical methods used in this study (e.g., small sample size, significant violations of equality of variances), the results should be interpreted with caution and require replication. What was noteworthy about this research was that the manner in which countertransference was conceptualized introduced interesting possibilities for future research.

Summary

To summarize, this section attempted to review some of the clinical, theoretical, and empirical research on countertransference. Although the clinical literature makes an important contribution to understanding the phenomenon, a major weakness of the literature on countertransference is the abundance of anecdotal reports and the paucity of empirical research. The empirical research on countertransference that does exist contains various limitations. Overall, the lack of research in naturalistic settings and the over-reliance on analogue research designs are a major weakness of the empirical research on countertransference. Based on the studies reviewed, there has been an over-reliance on self-report inventories with questionable validity in operationalizing countertransference. In order to have confidence in research results, one requires confidence in how the concepts have been operationalized (construct validity), as well as confidence in the methods used to study the phenomena.

Gelso and Hayes (2002a) succinctly captured this struggle:

> The likely culprits for the slow pace of research were twofold. First, countertransference originated from and was firmly embedded in psychoanalysis, a discipline containing a decidedly anti-empirical bent and an opposition to the simplification that appears to be an inherent part of scientific research. Second, and perhaps more telling, the construct itself is awesomely complex, focusing as it does on unconscious processes, defense mechanisms, and indeed often one person's unconscious reactions to another person's unconscious reactions. Add to these the definitional ambiguity that seems to be a part of virtually all high-level constructs, and

the road was paved for little research. (p. 3)

The authors note that the construct has generated much interest in recent years in terms of its impact on the therapy relationship. Countertransference is no longer a topic that is only of interest to psychoanalysts.

As stated earlier, this researcher subscribes to a "combined definition" of countertransference. From this perspective, countertransference is viewed as both positive and negative. Countertransference reactions, if understood, can facilitate empathic understanding; however, if unchecked, these reactions can interfere with the therapeutic process. In other words, there is a distinction between countertransference feelings and behaviour. Because the latter instances tend to be more problematic, this study focused on behavioural manifestations of countertransference. Thus, regardless of whether the therapist's countertransference reactions stemmed from his or her unresolved issues from past significant relationships (e.g., subjective countertransference) or from the client's issues and/or behaviour (e.g., objective countertransference), this study focused on observable behavioural manifestations of countertransference during therapy sessions.

Restatement of Purpose

To date there have been few attempts to observe countertransference behaviour during actual counselling sessions (e.g., Bandura et. al, 1960; Rosenberger & Hayes, 1998). Recent theoretical conceptualizations of countertransference have provided helpful frameworks to investigate the construct further (e.g., Hayes et al., 1998; Wilson & Lindy, 1994). In their preliminary theory of countertransference origins, triggers, and manifestations, Hayes et al. (1998) recommended that researchers "work backwards" and first try to identify countertransference manifestations (thoughts, feelings, and behaviours), then try to identify potential triggers and origins for the therapist.

Because the purpose of this research was to identify possible countertransference manifestations during actual counselling sessions, selecting criteria that were potentially observable was desirable, particularly when some have stated that countertransference manifestations are more likely to be observed by third parties (e.g., Singer & Luborsky, 1977). Thus, operationalizing countertransference behavioural manifestations as therapist over-involvement and under-involvement not only seemed heuristically sound, but was thought to

have both clinical and empirical value (Friedman & Gelso, 2000). Previous research focused solely on therapists' avoidance behaviour (e.g., Rosenberger & Hayes, 1998) and overlooked negative aspects of therapists' seemingly facilitative behaviours, such as over-supporting or colluding with clients. This broader conceptualization provided some flexibility in the range of potential therapist behaviours.

The purpose of this exploratory research was to address some of the limits of previous research by designing a study that attempted to identify behavioural manifestations of therapist countertransference reactions during actual counselling sessions. Specifically, this study addressed the following research questions:

1. Can countertransference behavioural manifestations, defined as therapist over-involvement and under-involvement, be reliably identified during counselling sessions with clients?
2. Is there evidence to support the contention that counsellor over-involvement and under-involvement are valid indicators of countertransference behaviour?

As will be described in the method chapter, in this study, judges' agreement constituted a reliable rating of over-involvement and under-involvement. In addition, Kiesler's (2001) suggestion to identify countertransference behaviour as therapist behaviour that "deviates from baseline" provided a guideline on selecting significant episodes of over-involvement and under-involvement based on each counsellors' typical response style.

Evidence that over-involvement and under-involvement were valid indicators of countertransference behaviour was investigated by triangulating multiple data sources to identify potential triggers in the dialogue preceding the behaviour (e.g., content of client dialogue, counsellor session notes, supervision notes, counsellor and supervisors' ratings). Hayes, McCracken, McClanahan, Hill, Harp, and Carozzoni (1998) hypothesized that countertransference triggers, defined as therapy events that elicit a reaction in the therapist, preceded countertransference behaviour. The more evidence that the preceding client dialogue contained triggers for the therapist, the more confidence one could have that over and under-involvement was an indicator of countertransference.

Chapter III

Method

This research sought to address two questions: one, can countertransference behavioural manifestations, conceptualized as counsellor over-involvement and under-involvement, be reliably identified by independent judges in a naturalistic setting; and, two, is there evidence to support the contention that counsellor over-involvement and under-involvement were valid indicators of countertransference behaviour? These research questions can be phrased more informally as, "can judges reliably identify counsellors' departures from empathic connection, defined as counsellor over-involvement and under-involvement" and "what are the triggers associated with counsellors' empathic failures?" Because of the complex nature of this study, the initial section of this chapter outlines the methods used to answer the research questions under the following five main headings: step 1: design and use of Generalizability Theory; step 2: recruitment of participants; step 3: treatment implementation and data collection; step 4: Decision (D) study: Question one; and, step 5: Qualitative (Q) study: Question two. A diagram illustrating the multiple and progressive steps of the method, and their relationship to each other, appears in Figure 2.

Step 1: Design

In order to study potential countertransference manifestations systematically, this study employed a mixed research design. This section briefly describes the rationale for applying Generalizability Theory (GT) and a Generalizability, or G study, with a multiple case study design. The decision and qualitative studies, henceforth referred to as the D and Q studies, are also described briefly to orient the reader. Further details regarding measurement of the research questions are provided below (e.g., steps 4 and 5).

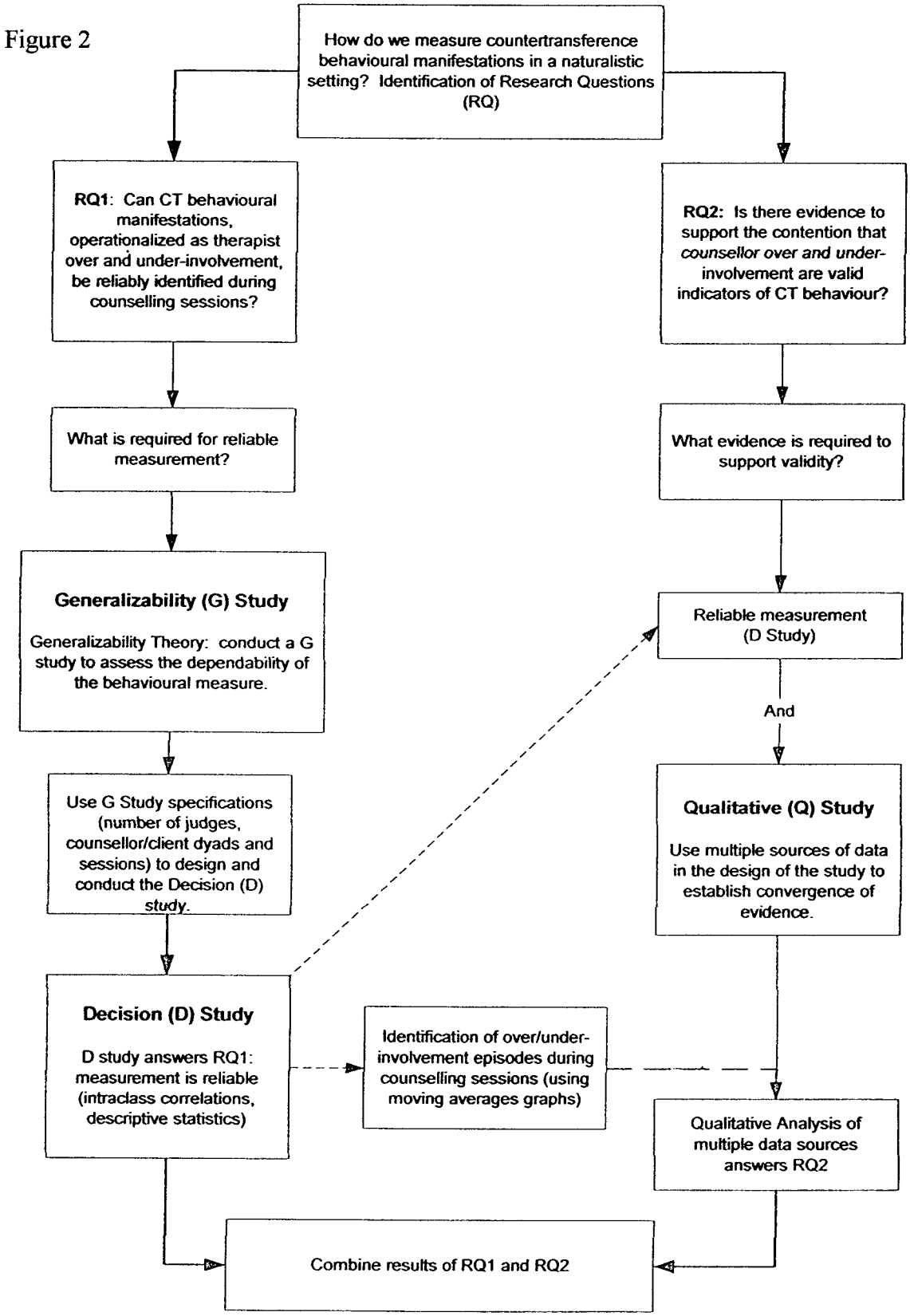
Multiple Case Study Research

A multiple case study approach was used to intensely analyze the intimate interaction that occurs between clients and their therapists. This approach was selected because it allowed a level of analysis that could yield insights concerning the therapeutic process that may have been overlooked by other research designs (e.g., Jones, 1993; Yin 1989).

Single and multiple-case research designs have various strengths. Heppner et al. (1992) identified the following advantages: first, they are a means of collecting information

Figure 2: Overview of Methodology

Figure 2



and ideas, and generating hypotheses about the therapeutic process; second, they are a means of testing therapeutic techniques and of testing new methodologies; and third, they are a means of studying individuals, rare phenomena, and of providing exemplars and counterinstances. In addition, single-case designs are versatile and can be employed creatively with a variety of phenomena (Galassi & Gersh, 1993). More recently, there has been more attention given to intensive single-case designs which incorporate repeated measures and adopt a systematic approach (e.g., Hilliard, 1993). This study employed video tapes of actual counselling sessions as the basis for the ratings of counsellors' countertransference behaviour.

Because research question two could not be addressed unless research question one could be answered with confidence, this study adopted methodology for the first question that would maximize the reliability of measuring countertransference behaviour, defined as over-involvement and under-involvement. This involved application of Generalizability Theory (GT; Cronbach, Gleser, Nanda, & Rajartnam, cited in Shavelson, Webb, & Rowley, 1989) described below, and conducting a preliminary study (the G study) to assess the dependability of the behavioural measure of countertransference and design the eventual investigation, termed the decision (D) study. In other words, the G study determined the necessary and sufficient number of counsellor-client dyads, counselling sessions, and judges required to achieve a desirable level of reliability in the D study. Once the primary investigation of research question one was completed, the study could then proceed to research question two.

Research question two required a different form of case study. In addition to the video taped counselling sessions for the counsellor/client dyads, multiple information sources were used to collect data. These data were then analyzed qualitatively in the Q Study.

Generalizability Theory

To address the dependability of the behavioural measure of countertransference, generalizability theory (GT; Cronbach, Gleser, Nanda, & Rajartnam, cited in Shavelson, Webb, & Rowley, 1989), a statistical theory about the dependability of behavioural measurements, was used to evaluate the reliability of the measurement. Although multiple case study research frowns upon applying sampling logic (i.e., a smaller number of

participants or events are thought to be a representative sample collected from the entire pool of participants or events) to case studies (Yin, 1994), it seems reasonable to query the dependability of the behavioural measure and to question whether events (i.e., therapist over-involvement and under-involvement) across time for a single therapist generalize to future events for that therapist. Because case study research has generally been criticized for lacking external validity, employing this mixed research design helped to protect against threats to external validity.

Generalizability theory (GT) has proved useful in gauging the dependability of behavioural measurements by assessing the multiple sources of measurement error and attempting to reduce their effects. Other researchers interested in assessing the dependability of their measures have applied generalizability theory to a variety of problems, in a variety of settings (e.g., Erlich & Shavelson, 1976). In GT, dependability describes the accuracy of generalizing from a person's observed score or rating on a measure (e.g., behavioural observation of countertransference manifestation) to his or her average score or rating across observations (Shavelson & Webb, 1991). Thus, a single rating, across one occasion, with one judge is not a fully dependable measure of the behaviour.

A central component of GT is that it differentiates between generalizability studies (G studies) and decision studies (D studies): "G studies estimate the magnitude of as many potential sources of measurement error as possible. D studies use information from a G study to design a measurement that minimizes error for a *particular* purpose." (Shavelson, Webb, & Rowley, 1989, p.923). Consequently, applying the principles of GT increases the reliability of the generalizations researchers can make from their findings obtained in a D study, as is the intent here.

The generalizability study. Two female, doctoral level counsellors from the Department of Counselling Psychology at the University of British Columbia and two of their clients participated in the G study. The counsellors were in their first year of doctoral study and were enrolled in a full day clinic practicum at a training facility in New Westminster. The clinic offers free counselling to members of the community by Master's and Doctoral level student counsellors. Clients at the clinic sign consent forms permitting their sessions to be videotaped and observed by the clinic team for supervision purposes. The two counsellor-client dyads who allowed their video-taped counselling sessions to be

released for this G study completed additional informed consent documents and were provided with a written description of the purpose of the study (see Appendix A).

Counsellor-Client dyads. Counsellor A was a White female in her middle to late thirties. She described her theoretical orientation as client-centred. Her client (client A) was a White female in her late thirties to early forties. Client A presented with relationship and parenting issues. She attended individual and joint sessions with her boyfriend and teenage daughter. Only sessions in which client A attended alone were included in the G study. The counselling sessions were conducted from September 1997 to March 1998 at the New Westminster Counselling Centre. The first and third sessions were analyzed in the G study.

Counsellor B was a White female in her early thirties. She described her theoretical orientation as client-centred. Her client (client B) was a White male in his early fifties. Client B presented with depression, career issues, and relationship difficulties. He attended individual sessions. The counselling sessions were conducted from September 1998 to March 1999 at the New Westminster Counselling Centre. The third and fourth sessions were analyzed in the G study. The first session of counsellor-client dyad B was used for training purposes.

Judges. Two judges participated in the G study. Both judges were White females in their early thirties. Judge A, the author, was a doctoral student in the department of Counselling Psychology at the University of British Columbia. She was in her final year of doctoral work. Her theoretical orientation was influenced by existential and psychodynamic theories. Judge B recently completed her final requirements for her Ph.D. in the department of Clinical Psychology at the University of British Columbia. Her theoretical orientation was primarily cognitive-behavioural. A third judge, Judge C, participated in the G study training as a "back up." Judge C graduated with her Master's degree in Counselling Psychology from the University of British Columbia in 1995. Her theoretical orientation was influenced by client-centred and cognitive theories. She has worked as a substance abuse counsellor since completing her degree.

Data preparation. Four counselling sessions (two from dyad A and two from dyad B) were transcribed verbatim for the G study. An additional session from dyad B was also transcribed for training purposes. In the transcripts, each statement made by the counsellor and client was numbered according to talking turns. For example, the clients' first statements

were numbered 1a and the counsellors' first statements, or responses, were numbered 1b. This numbering system was used throughout the transcript (e.g., 2a, 2b, 3a, 3b, etcetera).

Rating countertransference behavioural manifestations. Countertransference behavioural manifestations, operationalized as therapist over-involvement and under-involvement, were assessed by three trained judges observing video-tapes of counselling sessions, paired with verbatim transcripts, and rating each of the responses made by the counsellors using a 7-point Likert scale (i.e., +3 = over-involved, +2 = somewhat over-involved, +1 = possibly over-involved, 0 = empathic connection, -1 = possibly under-involved, -2 = somewhat under-involved, and -3 = under-involved). The judges' agreement for over or under-involvement constituted a rating of countertransference behaviour.

Bandura et al. (1960) originally developed a similar method of coding every counsellor speaking turn for countertransference behaviour and operationalized countertransference as avoidance behaviour. Their method and definition has been adopted by others (e.g., Hayes & Gelso, 1993; Rosenberger & Hayes, 1998). The G study applied the same method of rating each counsellor response, but expanded the operationalization of countertransference to include both over-involved and under-involved responses. By focusing solely on avoidance behaviour, previous research has overlooked negative aspects of therapist's seemingly positive behaviour, such as over-supporting and befriending the client.

In order to capture this broader conceptualization of countertransference, descriptors for the dimensions over-involvement and under-involvement were taken from the Inventory of Countertransference Behaviour (ICB; Friedman & Gelso, 2000). Counsellor over-involvement included items such as: seemed to agree too often with the client, over-supported the client, colluded with the client, frequently changed the topic, talked too much, acted in a submissive way. Counsellor under-involvement included items such as: treated client in a punitive manner, was critical of the client, spent time complaining, provided too much structure, inappropriately questioned the client's motives. Although Friedman and Gelso (2000) renamed the scales of the ICB, "Negative Countertransference" and "Positive Countertransference," for this research, the previous labels over-involvement and under-involvement were retained. The original labels were deemed easier to grasp conceptually for the purpose of training judges, and were consistent with others' conceptualization of

countertransference (e.g., Wilson & Lindy, 1994).

A third dimension, empathic connection, was added to provide definitions of appropriate counsellor behaviour to help judges differentiate the phenomenon under study. Counsellor empathic involvement included items such as: used facilitating skills such as reflection, summaries, clarification, labelling, and empathy to demonstrate an understanding of the client's experience and willingness to explore issues further, was warm and caring, appeared genuine in his/her interactions with the client.

Although the ICB is typically used to provide a global score of countertransference behaviour for the session, the current research was interested in capturing moments of countertransference behaviour within therapy sessions. Thus, the ICB descriptors were employed to assist judges in their ratings of each therapist response during the session. In other words, rather than providing a global rating of the therapists' behaviour for each session, the judges rated each therapist response for its level of countertransference behaviour using the ICB descriptors and empathy descriptors. A manual describing these dimensions was developed for the purpose of training the judges in the G study (see Appendix B). While watching the videotapes of the counselling sessions and reading the corresponding transcripts, the trained judges used the seven point Likert scale to rate each counsellor response according to his or her level of empathic involvement or over/under-involvement. They recorded their ratings using the rating sheet in Appendix B.

Training procedures. The author, Judge A, reviewed the training tape (dyad B's first session) along with the corresponding transcript. Ratings for each counsellor response were completed using the manual in Appendix B. The counsellor's responses were rated according to her level of over-involvement, under-involvement, and empathic involvement using a seven point Likert scale. The scale ranged from positive three at one end (over-involvement), zero in the middle (empathic involvement), and negative three at the other end (under-involvement). Once Judge A completed the ratings using the training tape, the training procedures were repeated with Judge B using the training tape, transcript, and manual.

Judge B was directed to read the instructions in the manual and to review the descriptors for counsellor over-involvement, under-involvement, and empathic involvement. An example of each counsellor behaviour, over-involvement, under-involvement, and empathic involvement, was shown from the training tape based on Judge A's initial ratings of

the training tape. Judge B, blind to the ratings, was directed to rate the three examples. Judge A and B were in agreement regarding the ratings for the three examples of counsellor behaviour.

Judge A and Judge B then proceeded to review the training tape, stopping at five minute intervals so Judge B could complete her ratings for that segment. Ratings between Judge A and B were compared after each five minute interval before proceeding to the next segment. Discrepancies in ratings of two points or more (e.g., Judge A rated the counsellor's response 0 and Judge B rated it +2) were discussed to help refine and clarify ratings. An attempt was made to come to consensus for those ratings (approximately 10 % of total number of ratings). Upon completing the ratings of the training tape, Judges A and B proceeded to rate separately the two sessions from dyad A and the two sessions from dyad B. Intra-class correlations were computed for the judges' ratings. The judges were trained to an agreement level of .82.

A third judge, Judge C, who later served as a rater for the D study, participated in a portion of the G study training. Although her data was not used for the G study, her training is described here. The training session with Judge C was less rigourous compared with the training of Judge B. Judge C was also informed to read the instructions in the manual and to review the descriptors for counsellor over-involvement, under-involvement, and empathic involvement. An example of each counsellor behaviour, over-involvement, under-involvement, and empathic involvement, was shown from the training tape. Judge C was encouraged to ask questions regarding the three dimensions she would be rating. At this point Judge C was requested to review the training tape and transcript and to record her ratings at five minute intervals. Unlike Judge B's training which involved comparing ratings at the end of every five minute segment, Judge A and C only compared and discussed ratings up to the first 15 minutes of the session. Judge C then proceeded to rate the remainder of the training tape on her own. She also completed the ratings for the two sessions from dyad A and the two sessions from dyad B.

Because this G study provided an opportunity to clarify both methodological and procedural issues, feedback from the judges concerning the procedures were elicited throughout the training. Suggestions from the judges included: 1) it was helpful to read through the transcripts first before watching the video taped sessions, 2) it was easier to

follow if the video was stopped after each two pages of transcript, and 3) it was easier to write ratings on the transcript right next to the talking turn and transfer them to the rating sheet afterwards.

G Study Results. The G study helped to design the current, or decision study (D study) by providing a statistical means of estimating the dependability of the behavioural measurement of countertransference manifestations for various combinations of judges, sessions, etcetera. Using information from the G study made it possible to reduce the amount of measurement error in the D study. This task was accomplished by computing variance components for each parameter of interest in the study (i.e., judge, sessions, therapists, interactions, error). G theory helps the researcher assess the major sources of variation so that unwanted variation can be reduced in collecting future data (D study) (Shavelson & Webb, 1991).

The object of measurement in the G study was therapist behaviour, denoted as therapist (t). The facets were sessions (s) and judges (j). This G study is described as a partially nested design because it had both crossed and nested effects: sessions were nested within therapists because there were two sessions per therapist and the sessions differed for both therapists. The judge facet was crossed with both sessions and therapists because each judge rated all the sessions for both therapists. With nested designs fewer variance components can be estimated separately (Shavelson & Webb, 1991). For example, because sessions are nested within therapists, it is impossible to separate the session main effect from the interaction between therapists and sessions.

A table containing the estimated variance components from the analysis of the two counsellors (e.g., percentage of total variance attributed by dyad, judge, and session) is contained in Appendix A. Table 1 below provides the estimated error variances based on the G study used in the present case and alternative D-study designs. It includes the variance estimates and generalizability coefficients (ϕ) for several combinations of facets (i.e., number of judges and sessions). The generalizability coefficient is comparable to the reliability coefficient (i.e., an intraclass correlation coefficient) in classical theory, which represents true score variance divided by expected observed-score variance (Shavelson & Webb, 1991). The formulas used to calculate the G coefficient are listed in Appendix A.

Table 1 Decision Study for Therapist Countertransference Behaviour Observations [(s:t) x j Design]

	G Study		Alternative D Studies				
Source of Variation	n'j = 1 n's = 1	2 2	2 5	2 10	3 6	3 8	3 10
Therapist (t)	.194	.194	.194	.194	.194	.194	.194
Judge (j)	.00003	.00002	.00002	.00002	.00001	.00001	.00001
Session:Therapist(s:t)	.028	.014	.0056	.0028	.0047	.0035	.0009
Therapist*Judge(tj)	0	0	0	0	0	0	0
Error(s:tj,e)	1.186	.2965	.1186	.0593	.066	.049	.0395
σ^2 Rel	1.214	.3105	.1242	.0621	.0707	.0525	.0404
σ^2Abs	1.214	.3105	.1242	.0621	.0707	.0525	.0404
p2	.14	.38	.61	.76	.73	.79	.83
ϕ	.14	.38	.61	.76	.73	.79	.83

Using one rater and one session to measure therapists' countertransference behaviour would yield low generalizability and phi coefficients (.14). Because the variability due to the residual term was substantial, it was necessary to increase the number of sessions and judges to reduce this source of unwanted variance. Given the time required to train judges, the decision to increase sessions more substantially than judges was made for practical purposes. In order to yield a generalizability coefficient of .79, the decision study included three judges, all rating the two counsellor-client dyads across 8 therapy sessions. A generalizability coefficient of .79 was within the range considered acceptable when assessing the dependability of a behavioural measure and was consistent with what other researchers have accepted when designing their D study (e.g., Shavelson, Webb, & Rowley, 1989).

Research Design Summary

To summarize, a mixed research design was used in this study. Multiple case research and Generalizability theory (e.g., G study) were integrated to design a study that intensely analyzed the interactions between clients and their counsellors and maximized the reliability and validity of measuring countertransference. The D study investigated research question

one and the Q study explored research question two.

The D study: Research question one. As noted above, the results of the G study helped to design the decision (D) study in a manner that increased the dependability of the behavioural measure of countertransference. The D study implemented the specifications from the G study to address the first research question. This question explored whether countertransference behavioural manifestations could be reliably identified during therapy sessions. Manifestations were operationalized as therapist departures from empathic connection or, more specifically, as over and under-involvement. This variable was assessed by three trained judges, who observed two counsellor-client dyads across sixteen counselling sessions (eight sessions each). The counsellors' behaviour was rated based on the same 7-point Likert scale employed in the G study. The judges' agreement constituted a rating of countertransference behaviour.

The Q study: Research question two. The Q study addressed the second research question. This question explored whether there was evidence that counsellor over and under-involvement were valid indicators of countertransference behaviour. To apply measurement theory logic to this research question, construct validity was investigated by identifying links between variables hypothesized to be related (Anastasi, 1988). Countertransference triggers, defined as therapy events that elicited a reaction in the therapist, are hypothesized as preceding countertransference behaviour (Hayes et al., 1998). Evidence supporting the validity of conceptualizing countertransference behaviour as over-involvement and under-involvement was accumulated by establishing a temporal relationship between countertransference triggers and behaviour. Potential triggers for the therapist were identified by reviewing various sources of information: 1) the content of the client's dialogue and emotional tone during the therapy sessions; 2) the counsellors' session notes; 3) the research supervision notes from two supervision sessions; and 4) ratings by the counsellors, the research supervisor, and the counsellors' previous supervisor regarding the counsellors' reactivity to various client issues. Further descriptions of the D and Q studies appear in subsequent sections of step 4 and 5.

Step 2: Recruitment of Participants

This study was promoted as a counsellor development project. Participants in this study included two counsellors, two clients, one clinical research supervisor, and three

judges. Descriptions of the recruitment procedures and participant demographics are provided in this section.

Counsellor Recruitment

Counsellors were invited to participate in this study to gain paid, supervised experience working with clients who have serious health concerns. They were recruited from three sources: 1) the pool of current and graduated Master's level counselling students from the Department of Counselling Psychology at the University of British Columbia; 2) the pool of graduated students from a two year counsellor training program (CURA Institute for Integrated Learning) in Vancouver, British Columbia; and 3) the pool of established counsellors in the local community.

Information packages regarding the study were posted within the Department of Counselling Psychology at the University of British Columbia asking counsellors to contact the primary researcher directly for an information package (see Appendix C). In addition, information packages were given to the clinical director of CURA Institute for Integrated Learning and to several psychologists conducting supervision with counsellors in the community. Again, counsellors interested in participating were asked to contact the primary researcher directly.

Four counsellors from the community and two counsellors from CURA contacted the researcher. There were several requirements for inclusion in the study. The counsellors had to have either completed a Master's degree in counselling psychology or be enrolled in a Master's program. If they were currently enrolled in a program, potential participants had to have completed all their clinical requirements. In addition, the counsellors had to have undergone supervised counselling experience as part of their program training and to have a recent clinical supervisor who would be willing to complete an evaluation of the counsellor. To participate, counsellors had to be available during the summer months when the study was being conducted. Of the six counsellors who responded, three met the above criteria.[1]

A meeting was arranged with therapists who satisfied the inclusion criteria to complete the following tasks: first, a general statement regarding the nature the study without disclosing the construct of interest was provided (see Appendix C); second, the time commitment and the therapist's responsibilities in the study were explained; and third, if acceptable to the therapist and the researcher, the therapist signed an informed consent form

and completed the demographic questionnaire (see Appendix D). The therapists were asked to contact a previous supervisor to inform him or her of their involvement in the study and to ask him or her to complete a brief evaluation of the therapist. They were given a package containing a general description of the study and the evaluation forms to be mailed to their previous supervisor (see Appendices C, E, and F). The packages also contained a self-addressed envelope for the supervisors to return the forms to the researcher. The therapists were also given the name and phone number of the research supervisor for the study and were asked to make initial contact with her before starting the therapy sessions.

During this meeting, therapists were given a tour of the counselling rooms in the Faculty of Education at the University of British Columbia and shown how to operate the audio-visual equipment. They were also given the following materials: 1) eight blank video and audio tapes, 2) eight session note forms (to be completed by the therapist after each therapy session), and 3) two copies of the Brief Symptom Inventory (BSI; Derogatis, 1993) (to be administered to the client after the fourth session and again after the final session).

Counsellors' demographics. Counsellor One was a 49 year old, White female. She was married with no children. She identified her ethnic background as Canadian European. She had a Master's degree in counselling psychology from the University of British Columbia, with four years of post-degree counselling experience. She described her theoretical framework as eclectic, and as influenced by Feminist, Existential, Narrative, Family Systems, and Psychodynamic theories. She had the most experience with the following client issues and populations: violence and abuse in relationships; women's issues (e.g., eating disorders, depression), cross-cultural, career, mid-life issues, and life transitions (e.g., divorce, illness, death). Counsellor One had previously worked as a writer before training as a counsellor.

Counsellor Two was a 55 year old, White male. He was divorced with no children. He identified his ethnic background as British. He was in the process of completing his Master's degree in mental health counselling from City University. He had also completed a two year intensive counsellor training program through CURA Institute for Integrated Learning. Including pre-university and university training, Counsellor Two reported eight years of pre-degree counselling experience. He described his theoretical orientation as eclectic, and as influenced by Client-centred, Brief Solution- Focused, and Narrative

approaches. He had the most experience with adults and youth and had completed an internship at a mental health clinic working with clients exhibiting a variety of psychiatric disorders. Counsellor Two had previously worked as a civil engineer before training as a counsellor.

Client Recruitment

Clients with serious health concerns were recruited through postings and information packages placed in local agencies and clinics serving this client population (see Appendices C and G). In addition, advertisements for the study were placed in local newspapers. Clients were invited to participate in this study in exchange for free counselling. Interested participants were asked to contact the primary researcher directly. This client population was selected because there is evidence that therapists experience a variety of emotional reactions when working with clients who suffer from serious health concerns (e.g., Hayes & Gelso, 1993). Because countertransference is a nebulous event to capture, particularly in its subtle forms, increasing the chances of it occurring by including client groups and issues identified as challenging for therapists seemed important.

Two individuals were referred to the study from local health care clinics serving patients with AIDS and cancer. Nine individuals with a variety of personal and health concerns responded to the advertisement in the local newspaper. The researcher conducted a preliminary screening interview with potential clients over the phone to ensure suitability for the study. The inclusion criteria were as follows: clients were currently experiencing serious health concerns; clients were not currently seeing another therapist; clients were emotionally stable enough to attend the eight counselling sessions (clients with active substance abuse problems, on-going psychotic episodes, or who were actively suicidal were not included); clients were willing to have the counselling sessions video-taped for the study; and, clients were available during the period in which the study was being conducted. Of the 11 respondents, three met the criteria for the study. Clients who were not selected for this study were provided with referrals to suitable free or low-cost counselling resources.

After initial contact over the phone, a meeting was arranged in the Faculty of Education at the University of British Columbia with the potential clients. The meeting served several functions: first, it was an opportunity to screen potential clients "face-to-face" for suitability for the study; second, the general purpose of the study, along with the

requirements of the study, were explained; third, if acceptable to the client and the researcher, the client signed an informed consent form (see Appendix C) and completed the demographic questionnaire (see Appendix D), the Brief Symptom Inventory (BSI; Derogatis, 1993) (see Appendix H); and lastly, the client was given a tour of the counselling office and an appointment was made to begin the counselling sessions the following week.

Clients' demographics. Client One was a 36 year old, White female. She was single and had no children. She identified her ethnic background as Canadian. Her highest level of education was a Bachelor of Arts degree. She identified her main concerns as "the unpredictable and potentially progressive nature of the chronic illnesses affecting me (MS and Chron's Disease). Emotionally, this leads to fear, depression, and lack of confidence."

Client Two was a 50 year old, White female. She was single and had no children. She identified her ethnic background as Celtic and was born in Scotland. Her highest level of education was a college degree. She identified her main concerns as "having rheumatoid arthritis and increasingly have degenerative joints. I worry about not remaining independent and all that that would entail. I had a hysterectomy in February and developed pulmonary embolism in my lungs."

Clinical Research Supervisor: Recruitment and Demographics

An experienced clinical supervisor was enlisted to provide supervision to the counsellors during the study. This was a different supervisor from the supervisors who completed the initial evaluations of the counsellors and was unacquainted with them prior to the study. The requirements for the clinical research supervisor were that: 1) he or she be a registered psychologist; and 2) he or she have at least three years experience supervising counsellors. A brief general description of the study was provided to the supervisor along with her responsibilities (see Appendix C).

The clinical research supervisor was a 45 year old, White female with 12 years experience as a Ph.D. level psychologist. She was working in a private therapy practice part-time and conducting supervision with therapists working at a mental health clinic part-time.

Judges

Three judges who were trained for the G study (Judges A, B, and C) served as judges for the current (D) study. The first two judges participated in the G study. The third judge participated in a portion of that training and was a full member of the judging team for the D

study.

Judges' demographics. All judges were White females in their middle thirties. The first judge (Judge A), also the researcher, was a Master's level clinical counsellor with seven years counselling experience. In addition to completing the requirements for a doctoral degree in counselling psychology, she worked part-time in a private therapy practice. The second judge (Judge B) was a Ph.D. level psychologist with eight years counselling experience. She worked in a Government facility conducting risk assessments for juvenile offenders as well as in a private therapy practice. The third judge (Judge C) was a Master's level clinical counsellor with seven years counselling experience. She worked as a therapist in a drug and alcohol clinic.

Step 3: Treatment Implementation and Data Collection

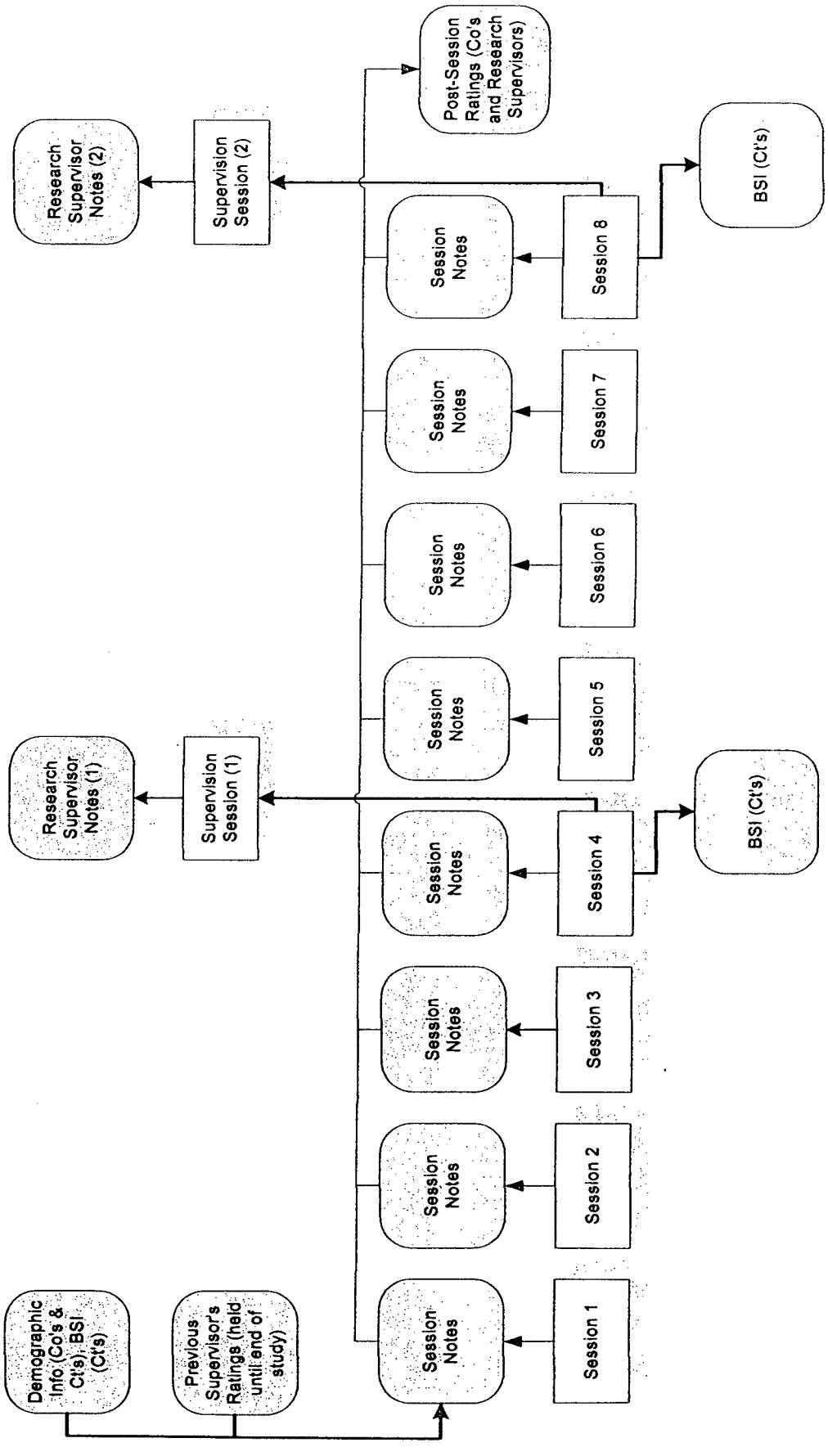
Figure 3 provides an overview of the order of treatment and data collection. As depicted in the diagram, several sources of data were collected from the counsellor (e.g., session notes, post-session self-report ratings), the counsellor's previous supervisor (e.g., pre-session ratings of counsellor) and the research supervisor (e.g., supervision notes, post-session ratings of counsellor). Various measures were also completed by the counsellors (e.g., demographic information), clients (e.g., demographic information, BSI), and supervisors (e.g., CFI-R) for descriptive purposes.

Treatment

The counselling sessions took place from July to September 2001. The client/counsellor pairings were randomly assigned. The researcher met the client and therapist together prior to their first session to facilitate introductions and respond to any questions. Therapy sessions were generally booked the same time every week for each counsellor-client dyad. The researcher and a university supervisor were always available on campus while the therapy sessions were being conducted in the event of any complications.

Treatment consisted of eight, 50-minute counselling sessions that were provided free of charge to the clients. Manualized treatment protocols were not used in this study, instead, therapists were permitted to conduct therapy as they deemed appropriate for their client. The counselling sessions were audio and videotaped. The therapists collected all materials after each session (i.e., video and audio-tapes, completed forms) and returned them to the researcher in the Department of Counselling Psychology at the University of British

Figure 3: Timing and Sources of Data Collection



Columbia.

Session Notes

After each session the counsellors completed notes outlining the content and the process of the therapy session. In addition, each counsellor was asked to respond to the following questions: 1) "From your perspective, what went well during the session and what was difficult during the session?" and 2) "What was most significant for you from this session?" This form is listed in Appendix I.

Supervision Sessions

Two individual supervision sessions were also provided to each therapist. The therapists were instructed to contact the clinical research supervisor and arrange a meeting within a week of their fourth and final counselling sessions. The supervision sessions took place at the supervisor's office. The clinical research supervisor was also available for additional sessions and phone contact throughout the study if deemed necessary.

The supervision sessions served two purposes: one, to fulfill ethical obligations to the client and the therapist; and two, to provide an opportunity to explore challenges and conflictual feelings aroused in the therapist by the counselling sessions. The supervisor's ratings of the therapists' reactions were incorporated in the data analysis to help identify potential countertransference triggers.

The clinical research supervisor was directed to keep the supervision sessions relatively unstructured, but to address the following general questions: 1) How do you find the sessions to date?; 2) What seems to be going well during the sessions?; and 3) Are there any issues that are posing a challenge for you? The final supervision session was similar in nature, with only minor revisions to the questions: 1) How did you find the sessions overall?; 2) What worked well between you and the client?; and 3) Were there any client issues that were challenging for you? These questions and the directions to the supervisor are contained in Appendix J.

Counsellors' and Supervisors' Ratings Identifying Potential Triggers

A list of items identifying a variety of client issues, interpersonal styles, and emotions were compiled and used to elicit ratings from the counsellor, his or her previous supervisor, and the research supervisor regarding potential countertransference triggers for each counsellor. The items pertaining to "client issues" were organized under five areas:

relationships, mental health issues, physical health issues, developmental period client was discussing (e.g., past versus present issue), and miscellaneous. The content areas were thought to represent common issues clients address in therapy. The list was given to several colleagues of the researcher to review and make recommendations. Each content area contained the item "Other" to include new information not covered in the list. The items depicting the client's interpersonal style were derived from the interpersonal circumplex literature, mainly Wiggins (1995) Interpersonal Adjectives Scales. The items describing the client's emotional tone were based on a list of feeling words condensed to six broad categories of feelings: mad, sad, peaceful, powerful, joyful, and scared.

The counsellor, his or her previous supervisor, and the research supervisor, were asked to rate the items using a five point Likert scale according to level of difficulty they believed the counsellor had with these issues (ranging from 0 = Not at all to 4 = Extremely). The counsellor and the research supervisor completed the ratings once all the therapy sessions were completed. The previous supervisors completed the ratings at the beginning of the study. Both the previous and the research supervisors were also asked to respond to the following question: "Given what you know about the counsellor's personal history and counselling skill, are there any other issues not already identified that he or she may be sensitive to in a counselling setting? Please explain." This question was attached at the end of the list of items described above. The counsellor was also asked to respond to a series of questions, such as, "Was there anything about this client's experience that you found difficult to work with?" The purpose of these questions was to encourage the counsellor to self-identify potential countertransference triggers. Appendix E contains the list of items and questions to the supervisors and counsellors.

Descriptive Measures

This study also included a variety of data collecting measures that yielded descriptive information about both clients and counsellors. These measures included: 1) a demographic questionnaire; 2) The Brief Symptom Inventory (Derogatis, 1993); and 3) The Countertransference Factors Inventory – Revised (Latts & Gelso, 1996).

Demographic questionnaire. Basic background information, such as age and gender, was collected from both the counsellors and clients for descriptive purposes. The counsellors' questionnaires also included questions concerning theoretical orientation and counselling

experience. Appendix D includes samples of these questionnaires.

Brief Symptom Inventory. Although the focus of this study was not to assess treatment outcome, the Brief Symptom Inventory (BSI; Derogatis, 1993) was included to identify client concerns for descriptive purposes. The BSI is a 53-item self-report inventory developed to assess psychological symptomology (see Appendix H). A five-point scale is used to rate the client's level of distress for each item (ranging from 0 = not at all to 4 = extremely). In addition to the 53 individual symptoms, the BSI contains nine primary symptom dimensions and three global indices. When testing the applicability of the BSI with college students, Hayes (cited in Rosenberger & Hayes, 1998) found evidence for six factors (Depression, Somatization, Hostility, Social Comfort, Obsessive-Compulsive, and Phobic Anxiety). The alphas ranged from .70 (Phobic Anxiety) to .89 (Depression) and the convergent validity correlations with a problem checklist ranged from .40 to .69 (Hayes, cited in Rosenberger & Hayes, 1998).

In addition to completing the BSI in the initial meeting, the clients were asked to repeat this measure on two other occasions, after the fourth session and after the last session. The counsellors were provided with copies of the BSI in envelopes. Upon completion of the fourth and the last session, the counsellors gave the clients the envelope containing the BSI and asked them to complete the measure in the counselling room. The clients were left alone to complete the measure. When the clients were finished, the counsellors collected the BSI and returned it to the researcher in the Department of Counselling Psychology at the University of British Columbia.

The Countertransference Factors Inventory - Revised. In order to assess the counsellors' ability to manage potential countertransference reactions, the research supervisor and previous supervisors were asked to complete The Countertransference Factors Inventory - Revised (CFI-R; Latts & Gelso, 1996). As with the other ratings, the previous supervisor completed the measure at the beginning of the study and the research supervisor completed it after the supervision sessions were finished.

The CFI-R contains 40 items reflecting five qualities: empathy, anxiety management, conceptualizing ability, self-insight, and self-integration (see Appendix F). Experts in the field of countertransference hypothesize that these qualities are important in the management of countertransference feelings (Van Wagoner, Gelso, Hayes, & Diemer, 1991). Supervisors

rate therapist-trainees on each item on a five-point Likert scale (ranging from 1 = strongly disagree to 5 = strongly agree). Higher scores on the CFI-R are thought to suggest greater countertransference management ability. Latts and Gelso (1996) report coefficient alpha estimates ranging from .85 to .96 for the subscales. When compared with therapists in general, excellent female and male therapists were thought to possess more of the characteristics, as defined by the CFI, required to manage countertransference feelings (Van Wagoner et al., 1991). This information was used for descriptive purposes to more fully understand the counsellors in the study.

Step 4: The D Study: Research Question One

The first research question is stated as follows: Can countertransference behavioural manifestations, defined as therapist over-involvement and under-involvement, be reliably identified during counselling sessions with clients? As described in step one, this research question had to be answered first before the second research question could be addressed. This section describes the data preparation, basis for judges' ratings, judges' training, and analysis used in the D study to answer the first research question.

Data Preparation

The 16 video-tapes of the therapy sessions (8 from dyad One and 8 from dyad Two) were transcribed verbatim. In the transcripts, each statement made by the counsellor and client was numbered according to talking turns. For example, the clients' first statements were numbered 1a and the counsellors' first statements, or responses, were numbered 1b. This numbering system was used throughout the transcript (e.g., 2a, 2b, 3a, 3b, etcetera). The video tapes of the counselling sessions and the corresponding transcripts were employed to rate countertransference behavioural manifestations. The judges viewed all the sessions in sequence (e.g., 1 through 8) and rated the counsellor's behaviour for over/under-involvement.

Rating Countertransference Behavioural Manifestations

As described earlier in the G study, countertransference behavioural manifestations, operationalized as therapist over-involvement and under-involvement, were assessed by three trained judges observing video-tapes of counselling sessions, paired with verbatim transcripts, and rating each of the responses made by the counsellors using a 7-point Likert scale (i.e., +3 = over-involved, +2 = somewhat over-involved, +1 = possibly over-involved, 0

= empathic connection, -1 = possibly under-involved, -2 = somewhat under-involved, and -3 = under-involved). The judges' agreement for over or under-involvement constituted a rating of countertransference behaviour.

The same manual described in Appendix B was employed for the D study. While watching the videotapes of the counselling sessions and reading the corresponding transcripts, the trained judges used the seven point Likert scale to rate each counsellor response according to his or her level of empathic involvement or over/under-involvement.

Judges' training. The same two judges who participated in the G study were used in the D study. The two G study judges (A and B) were joined by a third judge (C), as the G study indicated a need for three judges. The third judge also participated in a portion of the G study training but did not receive the same degree of training as the other two judges. The training procedures for the G study were described above. Four counselling sessions were rated in the G study by the three judges (two from Counsellor A and two from Counsellor B). The intraclass coefficients for the three judges' ratings for the four sessions was .72 and .76 for Counsellor A and .63 and .70 for Counsellor B. All three judges participated in further training for the D study (see below).

A week prior to commencing the ratings for the D study, the three judges met for approximately eight hours to discuss the rating system and compare ratings from the G study, including those that had included the third judge. The judges were given a copy of their ratings to review as the four videotapes from the G study were played. The tapes were stopped at five to ten minute intervals to discuss ratings. Approximately three hours of video-tape were observed. Anchoring ratings to the descriptors contained in the ICB helped to clarify discrepancies. At times judges experienced difficulty assigning a rating as over-involved or under-involved, if aspects of both dimensions were present in the counsellor's response. For example, the counsellor's response could be rated as under-involved (e.g., "was critical of the client") and over-involved (e.g., "talked too much). In those instances, judges were directed to assign the rating that they felt most represented the response. By the end of training, the judges had discussed and resolved differences in ratings of two points or greater.

To help the third judge gain additional training in conducting ratings, the three judges watched the first two sessions for each counsellor in the D study together. They made their

ratings independently, but at five to ten minute intervals the video was stopped so they could compare their ratings. Discrepancies in ratings of two points or more were discussed. At this point, judges could either keep their original rating or alter their rating if they found the discussion compelling. The altered rating was circled so that two reliabilities could be calculated, one for the "original rating" and one for the "revised rating." If reliability were above .75, the judges would cease to compare ratings in subsequent sessions. By the third session, judges' ratings converged so no additional consultation was necessary.

Data Analysis

Quantitative methods were used in the D study to analyze the first research question. First, descriptive statistics were calculated to provide an overview of the counsellors' response patterns (e.g., mean and standard deviation of judges' ratings, frequency of counsellor's over-involved and under-involved behaviour for each session). Second, interrater reliability for the judges rating the counsellors' behaviour was calculated using the intra-class correlation. Third, the judges' ratings were graphed for each session using the moving averages to depict the therapists' over-involved and under-involved behaviour. Each data point on the graph represented the mean of five counsellor responses, shifting forward by increments of one response (e.g., mean of responses 1-5, 2-6, 3-7, etcetera). The use of this graphing procedure allowed the researcher to detect subtle changes in the counsellors' response patterns. The graphs charted the therapists' departures from an empathic stance. The therapists' responses above one standard deviation from their mean were considered examples of countertransference behaviour and identified as "over-involved or under-involved episodes." These episodes were analyzed further in the second research question.

Step 5: The Q Study: Research Question Two

The second research question is stated as follows: Is there evidence to support the contention that counsellor over-involvement and under-involvement are valid indicators of countertransference behaviour? Research suggests that therapists may react to a variety of triggers, such as the content of client material, the client's emotional expression, and the client's presentation style that may lead to countertransference behaviour (e.g., Hayes et al, 1998; Latts & Gelso, 1995). It is theorized that therapists are more vulnerable to material (content, emotions, and/or styles) that is related to unresolved conflict within their own lives (e.g., Hayes et. al., 1998). This section describes the data preparation and analysis used in the

Q Study to answer the second research question.

Data Preparation

Countertransference triggers were assessed using qualitative research methods, mainly content analysis of the counsellor/client dialogue associated with the over/under-involved episodes identified as departures from the counsellor's typical pattern in the first research question, and by triangulation of other sources of data (depicted earlier in Figure 3). The qualitative analysis was conducted by the author. A grid was developed to organize the qualitative data into five columns: 1) client stimulus, 2) counsellor verbalizations, 3) session notes, 4) supervision session, and 5) ratings by counsellor, previous supervisor, and research supervisor regarding the counsellor's reactivity to a variety of client issues. The purpose of organizing the data in this manner was to attempt to identify potential triggers leading up to the counsellors' over/under-involved responses. Consistency in the various data sources would be considered evidence of a potential trigger.

Client stimulus. In order to identify the client stimulus, each over/under-involved episode reliably identified by the judges was highlighted on the corresponding transcript for each session. The dialogue preceding each over/under-involved episode was also reviewed to understand the factors leading up to the episode. This preceding dialogue, roughly 10 counsellor-client exchanges, was read several times by the author and the client's dialogue was analyzed for content and emotional tone using both the transcript and the corresponding videotape for the episode. The videotape was also reviewed to ensure that the emotional tone of the dialogue was accurately perceived. A brief descriptive statement was written to capture what was occurring in the session preceding the counsellor's over/under-involved reaction. This descriptive statement was labelled "Client Stimulus" and was written in the first column of the grid.

Counsellor verbalizations. An illustrative sample of the counsellors' reactions during the episode were recorded verbatim in column two of the grid and labelled "counsellor verbalization." The counsellors' reactions had already been identified as either over-involved or under-involved during the first research question. The complete transcription of each episode from the sessions is included in Appendices K and L.

Session notes. The corresponding session notes for the sessions containing the episodes were reviewed to identify potential triggers. Material from the session notes was

thought to be relevant if it related to the content of the dialogue recorded in the client stimulus and counsellor verbalizations for the episodes in that session. Particular attention was given to issues the counsellor self-reported as challenging. Material was considered a "direct reference" if the counsellor commented in the session notes about an experience during the session that could be clearly linked to the content of the client stimulus and counsellor verbalizations for the episode in question. Material was considered an "indirect reference" if the counsellor commented in the notes about a broader therapeutic challenge related to the episode in question, but did not have as strong a connection as a direct link (e.g., "I felt challenged when the client discussed her mother's suicide attempt," is a direct reference to a specific therapy event, whereas, "I sometimes feel helpless about the client's illness," is an indirect reference to a broader therapy issue). Direct and indirect references were recorded in column three of the grid labelled "Session Notes."

Supervision. As with the session notes, a similar procedure was followed with the supervision notes to identify potential triggers for the counsellors. The supervisor's notes from the two supervision sessions were reviewed for relevant materiel. Material from the supervision notes was thought to be relevant if it related to the content of the dialogue recorded in the client stimulus and counsellor verbalizations for the episodes in the counselling sessions preceding the supervision session. Particular attention was given to issues the counsellor found challenging. Again, material was considered a "direct reference" if the counsellor commented in the supervision session about an experience during a session that could be clearly linked to the content of the client stimulus and counsellor verbalizations for the episode the session. Material was considered an "indirect reference" if the counsellor commented during supervision about a broader therapeutic challenge related to the episode in question, but did not have as strong a connection as a direct reference. Direct and indirect references were recorded in column four of the grid labelled "Supervision."

Counsellors' and Supervisors' Ratings Identifying Potential Triggers. The list of items rated by the counsellor, his or her previous supervisor, and the research supervisor regarding potential countertransference triggers was reviewed by the primary researcher. The responses included client issues, interpersonal styles, and emotions that may serve as triggers for the counsellor. As with the session notes and supervision notes, items and comments related to the content of the client stimulus and counsellor verbalizations were deemed

relevant. These ratings were listed in the fifth column of the grid labelled "Ratings." Although this data source is furthest removed from the actual therapy event or episode, the ratings were examined for additional support to the direct and indirect references identified in the counsellor's session notes and the supervision notes.

Data Analysis

As noted above, the Q Study addressed the second research question by employing qualitative methods to investigate the validity of the behavioural measure of countertransference. First, the content and emotional tone of the clients' dialogue preceding the counsellors' countertransference manifestations were analyzed and compiled in a grid along with the other data sources (e.g., session notes, supervision session, and ratings by counsellors and supervisors). The over/under-involvement ratings served as the behavioural dimension of countertransference, whereas the other sources of data provided the cognitive and emotional elements. Second, by organizing the separate data sources into a grid, the data could be reviewed and compared, making it possible to identify common themes or potential triggers leading up to the counsellors' over/under-involved responses. If potential triggers in the client dialogue preceding the counsellors' over and under-involved behaviour received support from multiple sources of data in the grid, the validity of operationalizing countertransference manifestations in this manner would be supported.

Summary

To summarize, the primary goal of this research was to determine whether countertransference manifestations could be identified within therapy sessions in a reliable and valid manner. A generalizability (G) study was conducted to assess the dependability of the behavioural measure of countertransference and to design the decision (D) study (e.g., how many dyads, sessions, judges would be necessary to achieve a dependable measure of over/under-involvement). The G study also served to train the judges on rating the construct under investigation.

The D study addressed the first research question; the issue of reliability was explored by assessing judges' agreement on rating the counsellors' behaviour. The issue of validity was more complex because countertransference is a challenging construct to operationalize. The descriptors utilized to conceptualize countertransference were derived from the theoretical literature and limited empirical research. Over-involvement and under-

involvement only captures part of this complex construct. Further evidence supporting the validity of operationalizing countertransference in this manner was derived from the second research question.

The Q study addressed the second research question; evidence that over-involvement and under-involvement were valid indicators of countertransference behaviour was gathered by converging multiple data sources to identify potential triggers in the dialogue preceding the behaviour (e.g., content of client dialogue, counsellor session notes, supervision notes, counsellor and supervisors' ratings). If potential triggers could be found to precede countertransference behaviour, additional support for the construct could be established. In other words, if the supervisors and/or the therapist identified certain issues as "difficult" for the therapist, and the analysis of the therapy sessions indicated that when those same issues were addressed by the client the therapist responded in an over-involved or under-involved manner, then this finding may offer preliminary support that the behavioural observations of countertransference manifestations are in fact countertransference.

Chapter IV

Results

This chapter is organized as follows: first, the results from the client and counsellor measures are presented; second, the results from the quantitative analysis of research question one are described in the D Study; and third, the findings from the qualitative analysis of research question two are presented in the Q Study.

Counsellor and Client Measures

Countertransference Factors Inventory-Revised

The Countertransference Factors Inventory-Revised (CFI-R; Latts & Gelso, 1996) was administered to measure countertransference management. The ratings on the CFI-R range from 1 to 5, (e.g., 1 = strongly disagree to 5 = strongly agree), with higher scores reflecting better ability to manage countertransference reactions. The mean ratings for Counsellor One by the previous supervisor and the research supervisor were respectively as follows: self-insight 4.36 and 4.82; self-integration 4.45 and 5.00; anxiety management 3.75 and 4.75; empathy 4.45 and 4.82; and conceptual skills 4.00 and 4.22. The mean ratings for Counsellor Two by the previous supervisor and the research supervisor were respectively as follows: self-insight 4.00 and 3.82; self-integration 4.00 and 3.91; anxiety management 3.00 and 2.86; empathy 4.00 and 3.45; and conceptual skills 3.44 and 3.56. Anxiety management was the lowest rating for both Counsellor One (rating by previous supervisor) and Counsellor Two (ratings by both supervisors).

Brief Symptom Inventory

The Brief Symptom Inventory (BSI; Derogatis, 1993) was utilized to assess client functioning for descriptive purposes. The BSI was administered on three occasions (i.e., prior to commencing therapy, at the mid-point, and after completion of therapy). Scores were calculated for each of the nine factors, as well as the Global Severity Index (GSI).

Client One's mean scores for the three test occasions were as follows (range = 0-4): Somatization, 0.14, 0.0, 0.29; Obsessive-Compulsive, 1.33, 0,5, 1.17, Interpersonal Sensitivity, 0.5, 0.25, 0.5, Depression, 1.00, 1.33, 1.33, Anxiety, 0.67, 1.33, 0.5, Hostility, 0.2, 0.2, 0.2; Phobic Anxiety, 0.0, 0.0, 0.0; Paranoid Ideation, 0.2, 0.0, 0.0; Psychoticism, 0.6, 0.2, 0.2. Using adult female non-patient norms, her T scores on the GSI were 58, 43, 58,

respectively. Scores within this range suggest that Client One was not reporting any major symptomology.

Client Two's mean scores for the three test occasions were as follows (range = 0-4): Somatization, 2.29, 2.85, 3.43; Obsessive – Compulsive, 3.00, 3.83, 3.5; Interpersonal Sensitivity, 1.25, 2.0, 1.25; Depression, 1.33, 2.16, 2.16; Anxiety, 1.33, 2.00, 1.5; Hostility, 1.00, 1.00, 0.6; Phobic Anxiety, 0.2, 1.4, 1.6; Paranoid Ideation, 0.6, 2.4, 1.4; Psychoticism, 0.00, 1.4, 0.8. Using adult female non-patient norms, her T scores on the GSI were 69, 74, 71, respectively. Scores within this range suggest that Client Two was reporting some major symptomology. The factors that appeared to be contributing to the elevated GSI score were Somatization and Obsessive –Compulsive.

There did not appear to be change in pre and post measures of the BSI for either client. Client One's GSI score was lower than Client Two's across all three testing occasions. Client One's GSI score went down at the mid-point, indicating a decrease in the number and the intensity of symptoms, whereas Client Two's GSI score increased at the mid-point.

The D Study: Research Question One

The first research question queried whether countertransference behavioural manifestations could be reliably identified during counselling sessions. Judges' agreement for over or under-involvement by counsellors constituted a rating of countertransference behaviour. This section presents the following results: descriptive statistics, interrater reliability, and identification of over-involved and under-involved episodes.

Descriptive Statistics

Descriptive statistics, including frequency distributions, means, and standard deviations were used to describe the judges' ratings of over-involvement and under-involvement. Table 2 reports each judges' distribution of ratings when all the therapy sessions were combined. Frequency distributions for the judges' ratings for each counsellor across sessions one through eight are presented in Appendix K. The majority of the ratings for all judges clustered around "empathically involved" (0) and "possibly over or under-involved" (+1 or –1). A small percentage of ratings were at "somewhat over or under-involved (+2 or –2) and ratings at "over or under-involved" (+3 or –3) were negligible for all judges. It appears that Judge One assigned fewer ratings at "empathically involved" and more

ratings at "somewhat over-involved" for both Counsellor One and Two in comparison to Judges Two and Three.

The mean over-involvement/under-involvement rating by each judge rating both counsellors across the eight sessions is presented in Table 3. The Likert scale used in this study ranged from +3 (over-involvement) through to –3 (under-involvement). Empathic involvement received a rating of zero and was anchored in the middle of the scale. The

Table 2

Frequency Distribution: Percentage of Judges' Ratings Across Therapy Sessions*

Ratings	Judge 1	Judge 2	Judge 3
	Counsellor 1 / 2	Counsellor 1 / 2	Counsellor 1 / 2
Under-Involved (-3)	.1 / .15	0 / .85	.1 / .45
Somewhat Under-Involved (–2)	2.03 / 6.02	2.45 / 7.59	2.85 / 6.08
Possibly Under-Involved (-1)	17.27 / 25.30	14.00 / 23.17	10.24 / 24.43
Empathically Involved (0)	44.50 / 29.50	56.70 / 44.10	65.20 / 48.30
Possibly Over-Involved (+1)	29.64 / 33.20	20.00 / 18.43	19.16 / 17.77
Somewhat Over-Involved (+2)	6.47 / 5.78	6.77 / 5.71	2.45 / 2.82
Over-Involved (+3)	0 / .15	.1 / .15	0 / .15

* Sessions 1, 2, and 8 were eliminated before calculating the percentages because of low inter-rater reliability.

mean represents judges' average assessment of the counsellor's movement away from empathic involvement, assigned a rating of zero. In order to calculate the mean rating for each session, the data was re-coded to eliminate the positive and negative signs, otherwise the ratings would cancel each other out and result in an artificially smaller mean (i.e., closer to zero). Because the counsellors' movement away from empathic involvement was central to this study, the rationale for dropping the negative and positive signs was appropriate. The direction of the ratings was determined by referring to the raw data. Although the means are positive, the scores reflect the counsellor's average distance from empathic involvement (0) in either direction (i.e., +over-involvement or –under-involvement). The three judges' ratings were averaged to derive a combined score (mean) for each session. In addition, a grand mean was calculated for each judge and for the combined score across all the sessions.

Overall, the mean ratings for all three judges were higher for Counsellor Two than Counsellor One. There also seemed to be a pattern in the grand mean ratings: Judge One's

ratings for both counsellors were higher than Judge Two and Three's ratings and Judge Two's ratings were higher than Judge Three's.

Table 3

Mean Ratings of Over/Under-Involvement for Counsellor 1 and 2*

Counsellor 1		Judge 1	Judge 2	Judge 3	Combined Score
	n	M / SD	M / SD	M / SD	M / SD
Session 1	101	.52/.54	.46/.67	.32/.51	.43/.42
Session 2	204	.73/.60	.47/.69	.47/.63	.56/.48
Session 3	128	.86/.68	.76/.76	.69/.76	.77/.58
Session 4	122	.74/.65	.39/.57	.52/.63	.55/.52
Session 5	167	.52/.56	.39/.62	.35/.54	.42/.47
Session 6	144	.61/.67	.47/.67	.22/.45	.43/.52
Session 7	134	.54/.60	.67/.62	.30/.48	.50/.47
Session 8	227	.48/.51	.33/.53	.20/.45	.33/.37
Grand Mean**	695	.64/.64	.53/.67	.40/.60	.53/.52
Counsellor 2		Judge 1	Judge 2	Judge 3	Single Score
	n	M / SD	M / SD	M / SD	M / SD
Session 1	383	.88/.63	.78/.58	.55/.61	.74/.49
Session 2	432	.88/.46	.73/.59	.49/.67	.70/.44
Session 3	362	.93/.62	.91/.76	.77/.72	.87/.57
Session 4	229	.71/.60	.67/.68	.70/.69	.69/.52
Session 5	295	.77/.57	.68/.65	.47/.65	.64/.49
Session 6	261	1.10/.63	.87/.82	.72/.62	.90/.58
Session 7	237	.57/.59	.31/.51	.37/.56	.41/.44
Session 8	212	1.06/.67	1.01/.68	.52/.66	.86/.51
Grand Mean**	1384	.83/.63	.71/.73	.62/.67	.72/.55

*The 7-point Likert scale used for rating the counsellors' behaviour ranged from –3 (under-involvement) to +3 (over-involvement). Empathic connection (0) was anchored in the middle of the scale. The positive and negative signs were eliminated to calculate the means. The mean represents the counsellor's average "movement away" from an empathic connection, in either an under-involved or over-involved direction.

** Sessions 1, 2, and 8 were eliminated before calculating the grand mean because of low inter-rater reliability.

Reliability

As reported earlier in the methods section, each counsellor response or talking-turn during each session was rated for over-involvement, empathic involvement, and under-

involvement using a seven-point Likert scale. To assess interrater reliability, intraclass correlations were performed for the three judges' ratings of the counsellors' behaviour. The intraclass correlations for the three judges are reported in Table 4. They ranged from .54 to .84 for Counsellor One and .63 to .84 for Counsellor Two. The reliability of the three judges' ratings across all eight sessions was also assessed using the intraclass correlation. Coefficients of .76 and .79 were obtained for Counsellor One and Two, respectively. Research employing Bandura et al.'s (1960) coding system for approach-avoidance behaviour reported similar interrater reliability coefficients (this coding system operationalized countertransference behaviour as avoidance reactions and facilitative counsellor behaviour as approach reactions). Hayes and Gelso (1993) reported coefficients of .60, .66, and .79 for pairs of raters in their analogue research design. By the end of training, Rosenberger and Hayes (2002) reported interrater agreement for the approach-avoidance classification as .75, .80, and .80 for pairs of judges. The authors'

Table 4

Inter-rater Reliability: Intraclass Correlation for Three Judges

	7-point Likert Scale	
	Counsellor 1	Counsellor 2
Session 1	.54	.63
Session 2	.61	.66
Session 3	.81	.83
Session 4	.77	.84
Session 5	.82	.81
Session 6	.84	.82
Session 7	.84	.81
Session 8	.66	.75

case study obtained a generalizability coefficient of .62 for judges' agreement of avoidance behaviour. Although employing a different coding system, these studiesprovide a basis for comparing the ratings of the current study. Overall, the judges' ratings of counsellor over-involvement and under-involvement were deemed reliable, supporting the first research question. To ensure that a reliable sample of countertransference behaviour was utilized for the second research question, only sessions above .75 were analyzed further.

As described in the methods section, sessions one and two were used to recalibrate the judges' ratings given the lapse in time between the training sessions for the generalizability study, addition of a third judge, and commencing the decision study. The three judges watched the sessions together, making their ratings independently. The videotape was stopped approximately every five minutes so the judges could compare and discuss their ratings. Only the judges' original responses were included to assess reliability, however. After their discussions regarding the ratings, the judges' recorded any changes to their ratings beside their first rating. The "revised" ratings were circled to differentiate them from the "initial" ratings. The initial reliability coefficients for sessions one and two were .54 and .61 for Counsellor One and .63 and .66 for Counsellor Two. The revised reliability coefficients were .78 and .83 for Counsellor One and .87 and .85 for Counsellor Two.

Because the initial reliability coefficients for sessions one and two were low, the judges watched sessions three and four together. Again, the ratings were made independently, but the judges compared their responses and discussed ratings two or more points apart (e.g., 0 vs. 2, -2 vs. +2). The intra-class correlation for sessions three and four were deemed adequate so the judges rated the remaining sessions without comparison of ratings.

The reliability coefficient dropped for session 8 for both counsellor one and counsellor two. The drop in the reliability coefficient could not be accounted for by reduced variability in the judges' ratings (e.g., reliability decreases if the range of ratings is restricted). It is possible that the drop in the reliability coefficient in the eighth session could indicate a need to repeat calibration of judges' ratings with this method of assessing countertransference manifestations. Judges reported difficulty at times assigning directional ratings (e.g., over-involvement or under-involvement) when the counsellor's response included aspects of both dimensions. In addition, it is possible that the judges' ratings may have "drifted" by the eighth session. For example, without the opportunity to discuss the ratings, the judges' subjectivity may have influenced their ratings more strongly over time. Anchoring ratings to the behavioural criteria seemed to help judges during the training sessions. Thus, re-calibrating ratings more frequently may be necessary to maintain high reliability across numerous sessions.

Intraclass correlations were also performed for pairs of judges. Table 5 contains the correlations between Judges One and Two, One and Three, and Two and Three. Judges One and Two generally appear to have slightly higher reliability coefficients for both Counsellor One and Two compared to the other combination of judges.

Table 5

Inter-rater Reliability: Intraclass Correlation for Pairs of Judges

	Judges 1 & 2 Counsellor 1/2	Judges 1 & 3 Counsellor 1/2	Judges 2 & 3 Counsellor 1/2
Session 1	.40/.59	.54/.57	.38/.41
Session 2	.38/.66	.67/.50	.45/.53
Session 3	.83/.78	.71/.78	.68/.73
Session 4	.63/.87	.69/76	.77/.72
Session 5	.80/.79	.71/.71	.74/.71
Session 6	.85/.84	.73/.63	.73/73
Session 7	.85/.71	.74/.79	.69/.73
Session 8	.65/.77	.46/.58	.62/60

Identification of Countertransference Episodes

In order to track the counsellors' movement away from empathic involvement towards over or under-involvement, the judges' ratings for each session were depicted in linear graphs using moving averages. Each data point on the graph represented the moving average for the judges' ratings of five of the counsellor responses or talking turns. For example, the first data point represents the mean of ratings one to five, the second data point represents the mean of ratings two to six, the third data point represents the mean of ratings three to seven, etcetera.

The Y axis represented the judges' ratings (from empathic involvement (0) to over or under-involvement (3)) and the X axis represented the counsellors' talking-turns during the session. As with calculating the means, the data was re-coded to eliminate the positive and negative signs before constructing the graphs. A greater degree of movement from the X axis indicated that the counsellors' behaviour was rated as a departure from empathic involvement, into either over or under-involvement. Whether a peak on the graph represented

over or under-involvement was determined by referring to the raw data. The moving averages for the judges' combined score for Counsellor One and Two is represented in Graphs 1 through 10. Appendix L contains Graphs 11 to 20 depicting the judges' separate ratings for Counsellor One and Two, respectively.

The grand mean and standard deviation for the judge's combined score was used to determine a cutoff point for each counsellor. Only those ratings one standard deviation above the grand mean for a specific counsellor were analyzed further and were labelled as "significant episodes" for that counsellor. The counsellors' grand mean and standard deviation were employed for the cutoff (rather than the session mean and standard deviation or a uniform cutoff point), because it was thought to more accurately represent a divergence from his or her "typical" response pattern. The line drawn across the graph denotes one standard deviation above the counsellors' grand mean. For Counsellor One the cutoff point was 1.05 and for Counsellor Two the cutoff point was 1.27. Across sessions three to seven, a total of 13 episodes were above the cutoff point for Counsellor One and 20 episodes were above the cutoff for Counsellor Two.

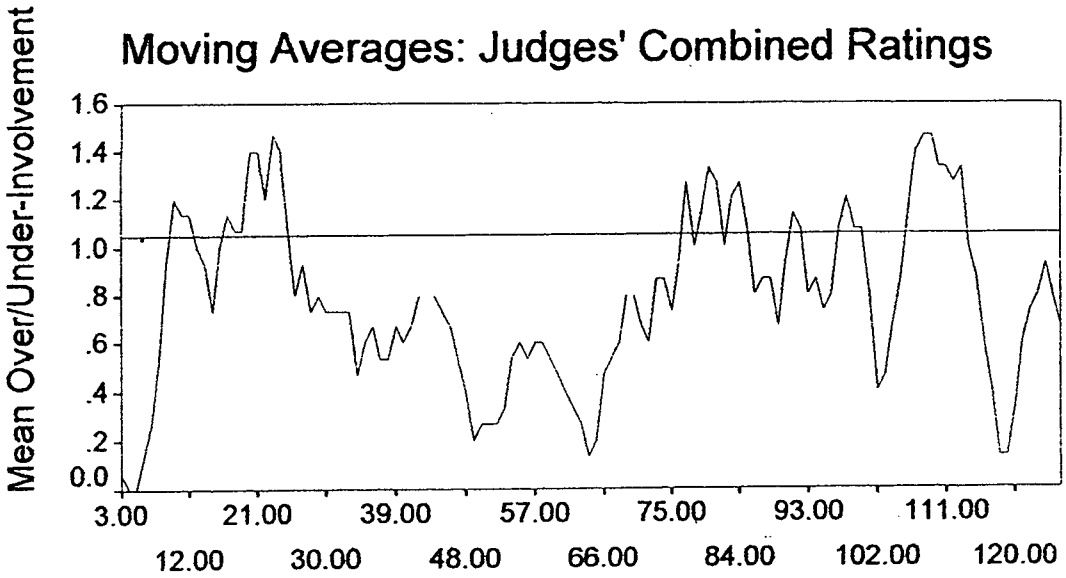
The Q Study: Research Question Two

Research question two addressed whether there is evidence to support the contention that counsellor over and under-involvement were valid indicators of countertransference behaviour. Research question two was analyzed qualitatively: first, this section will discuss how support for over and under-involvement as countertransference manifestations was established; and second, common themes or potential triggers that emerged from the data will be identified.

Convergence of Data Sources: Establishing Support for Episodes as Indicators of Countertransference

The 13 episodes for Counsellor One and 20 episodes for Counsellor Two identified in research question one as departures from the counsellor's typical pattern were analyzed qualitatively in order to illustrate counsellor over and under-involved behaviour and investigate potential triggers for the counsellor. As described earlier in the methods (see Figure 3), multiple sources of data (i.e., session notes, supervision notes, counsellors' ratings, and previous supervisors' and research supervisor's ratings) were converged to investigate the second research question. This data was compiled in a grid containing five columns:

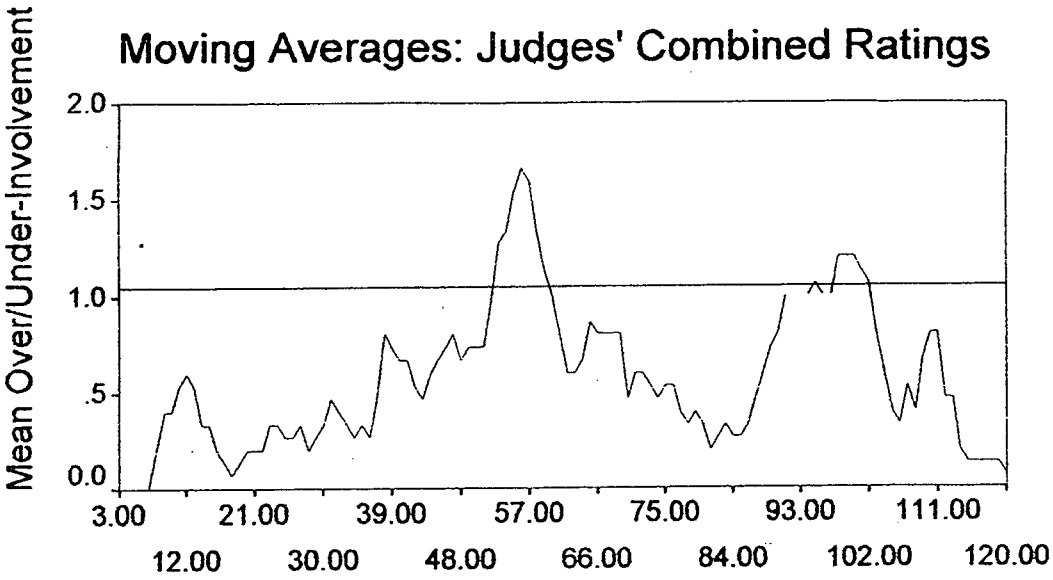
Graph 1



Counsellor 1 Session 3

Cutoff = 1.05

Graph 2

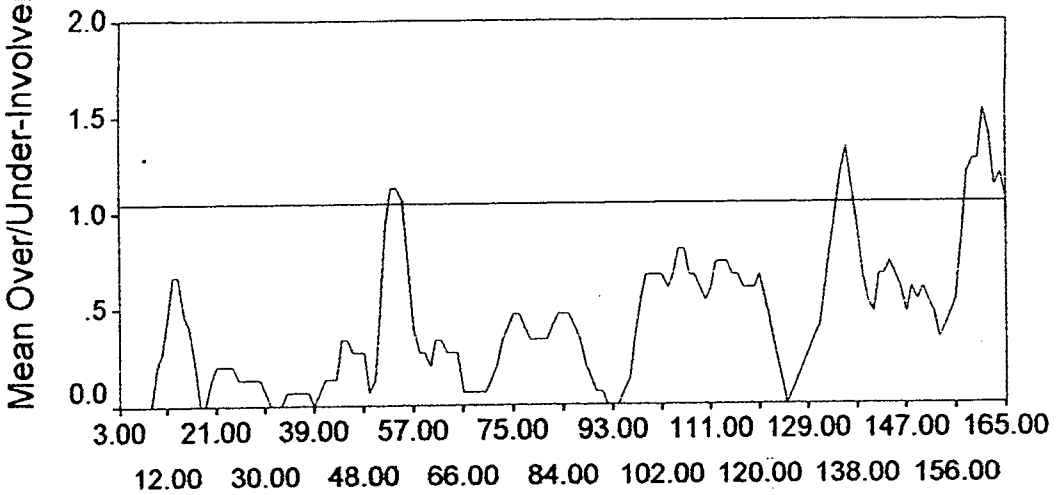


Counsellor 1 Session 4

Cutoff = 1.05

Graph 3

Moving Averages: Judges' Combined Ratings

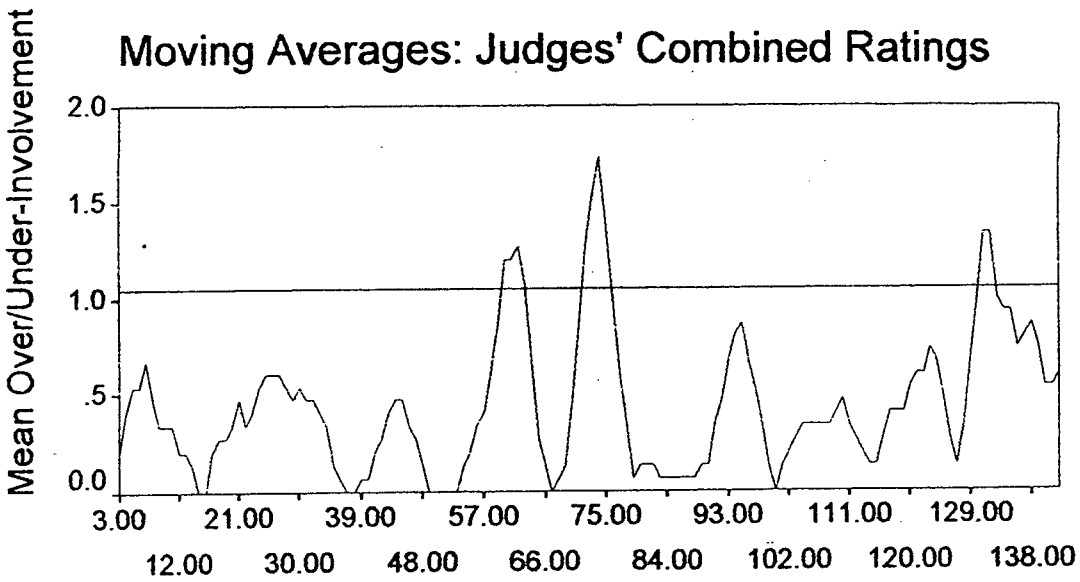


Talking Turn

Counsellor 1 Session 5

Cutoff = 1.05

Graph 4

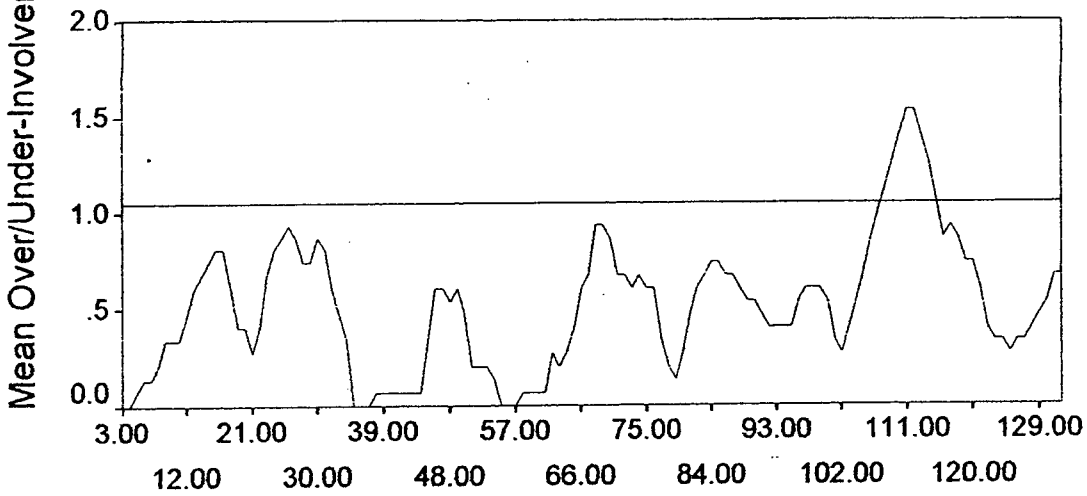


Counsellor 1 Session 6

Cutoff = 1.05

Graph 5

Moving Averages: Judges' Combined Ratings



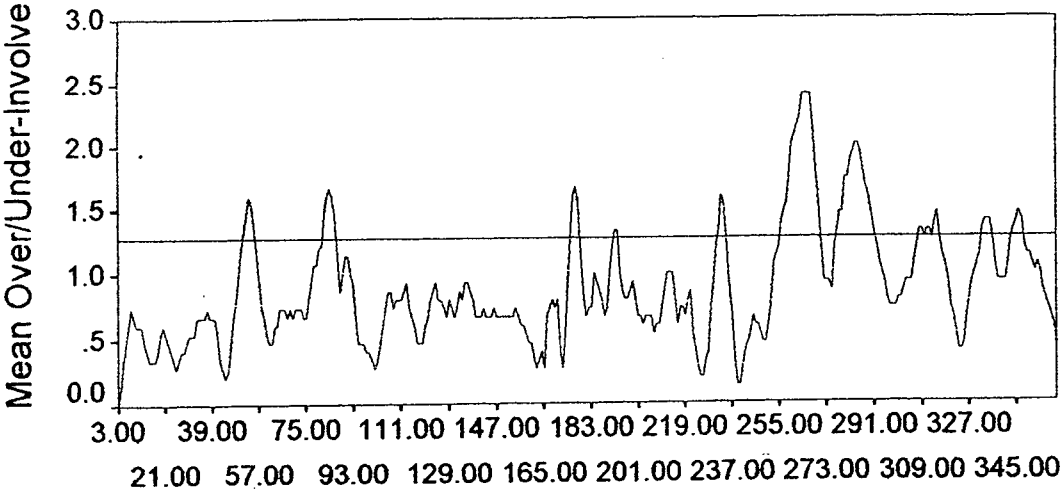
Talking Turn

Counsellor 1 Session 7

Cutoff = 1.05

Graph 6

Moving Averages: Judges' Combined Ratings



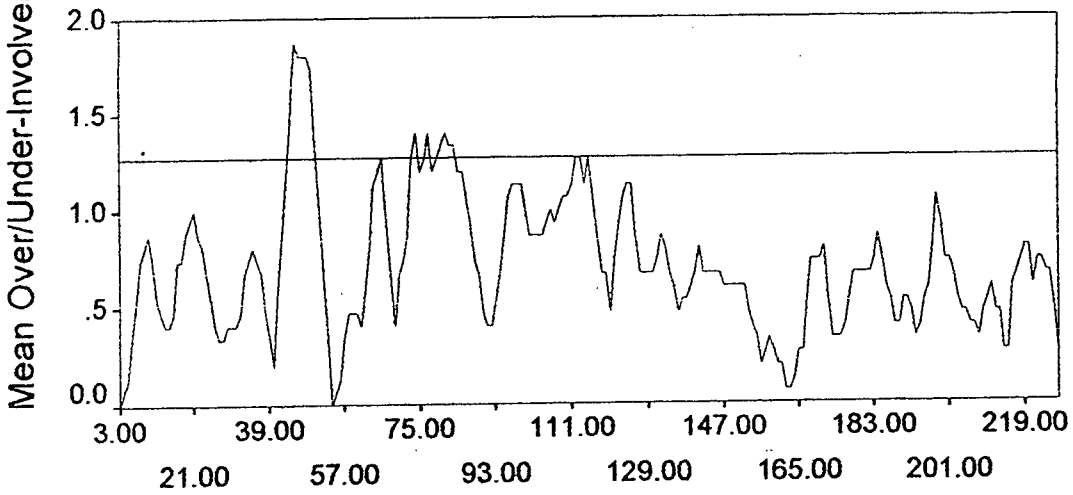
Talking Turn

Counsellor 2 Session 3

Cutoff = 1.27

Graph 7

Moving Averages: Judges' Combined Ratings



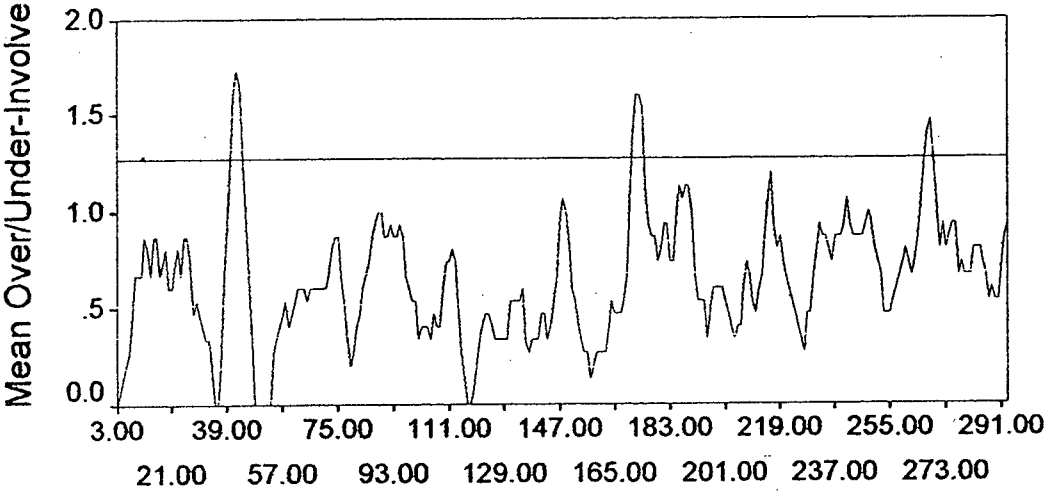
Talking Turn

Counsellor 2 Session 4

Cutoff = 1.27

Graph 8

Moving Averages: Judges' Combined Ratings



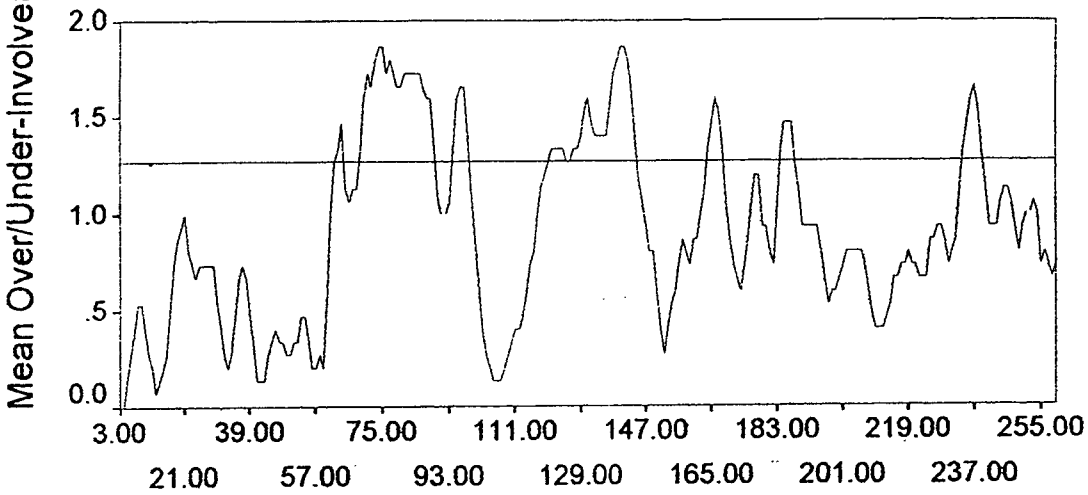
Talking Turn

Counsellor 2 Session 5

Cutoff = 1.27

Graph 9

Moving Averages: Judges' Combined Ratings



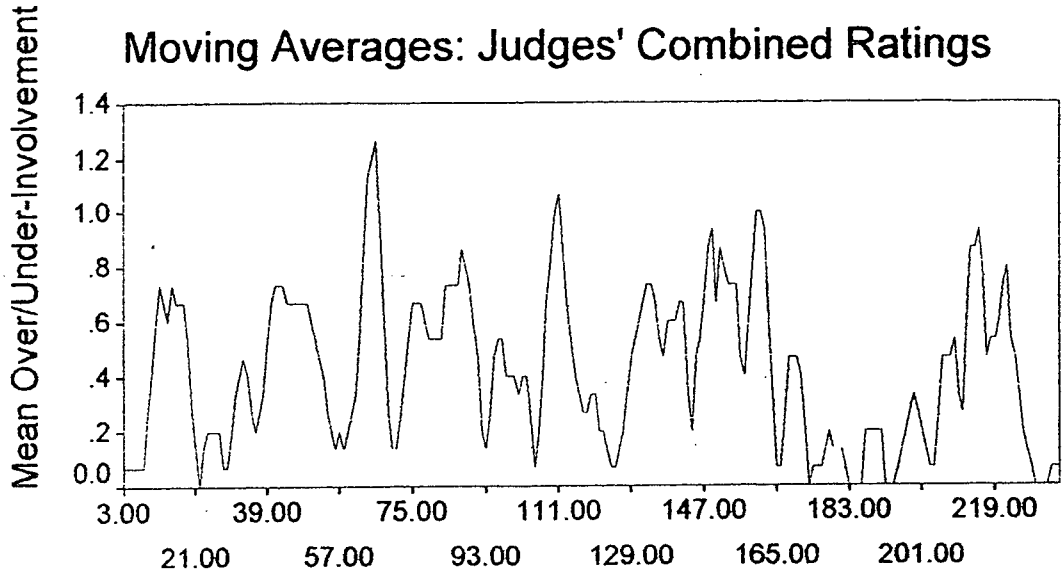
Talking Turn

Counsellor 2 Session 6

Cutoff = 1.27

Graph 10

Moving Averages: Judges' Combined Ratings



Talking Turn

Counsellor 2 Session 7

Cutoff = 1.27

1) client stimulus (e.g., potential triggers), 2) counsellor verbalizations (e.g., over and/or under-involved response), 3) session notes, 4) supervision notes, and 5) counsellors' and supervisors' ratings.

Tables 6 and 7 depict this grid for Counsellor One and Two, respectively. The tables appear at the end of this section starting on page 118. A description of the dialogue between the counsellor and client preceding the counsellor over and under-involved response is included in column one (client stimulus). Direct quotations from the over and under-involved episodes are reported in column two (counsellor verbalizations). Relevant data from the session notes, supervision sessions, and ratings by the counsellor and supervisors were included in the remaining columns of the grid. The full transcription of this information was not included to protect the counsellors' and clients' confidentiality.

Evidence that over and/or under-involvement were valid indicators of countertransference behaviour was established by gathering support for potential triggers in the client stimulus. Direct confirmation for a therapy event or trigger was determined to exist if the event in the client stimulus was directly referred to by the counsellor as problematic in either the session notes, the supervision session, or the post-session ratings. Indirect confirmation for a trigger was determined to exist if the event or content and emotional tone of the client stimulus was identified by the counsellor or supervisors as a difficult issue for the counsellor, but was not specifically referred to by the counsellor. In other words, although the counsellor may not have directly identified an event during the episode as "difficult," if the content and emotional tone of the client dialogue (client stimulus) contained issues identified in the supporting data as "challenging" for the counsellor, then the episode was deemed to have indirect confirmation.

The qualitative analysis of the data suggested that there was preliminary support for identifying potential triggers – or therapy events that elicited a reaction in the therapist – for both Counsellor One and Two. Of the 13 episodes identified for Counsellor One, four episodes had direct confirmation from the supporting data regarding the triggers identified in the client stimulus (session 3: episodes 1 and 3; session 5: episode 1; and, session 7: episode 1.) The remaining 9 episodes had indirect confirmation from the supporting data for the triggers identified in the client stimulus. Of the 20 episodes identified for Counsellor Two, six episodes had direct confirmation from the supporting data regarding the triggers

identified in the client stimulus (session 3: episode 6, 7; session 4: episodes 1, 2, and 3; and, session 5: 2). The remaining 14 episodes had indirect support for the triggers identified in the supporting data.

Interestingly, some episodes were identified by the counsellors as "helpful" in the session notes, but were rated by the judges as over-involvement and/or under-involvement . For example, judges rated Counsellor One's behaviour as under and over-involved for episodes 2 and 3 in session 5, respectively, whereas Counsellor One identified those episodes as "what went well" during the session. Similarly, the judges rated Counsellor Two's behaviour as either over and/or under-involved for session 4
episode 4 and session 6 episodes 2, 3, and 5, whereas Counsellor Two identified those episodes as "what went well" during the session.

Direct and Indirect Confirmation: Counsellor One

Based on the data converged in Table 6, the episodes that received direct and indirect confirmation for the triggers are summarized below for Counsellor One. Episodes with direct confirmation (DC) are presented first, followed by those that received indirect confirmation (IC). For the episodes that received direct confirmation (e.g., DC), only the datum source that included direct support for the potential trigger(s) in the client stimulus is reported below. For the episodes that received indirect confirmation (e.g., IC), all the data sources that "build a case" for the potential trigger(s) in the client stimulus are described below.

Session 3: episode 1 (DC). The client stimulus involved discussion of loss of bowel control. The counsellor reported feeling challenged by the discussion of this health issue in her session notes.

Session 3: episode 3 (DC). The client stimulus involved discussion of mother and aunt's suicide attempts. The counsellor reported feeling challenged by the discussion of these particular family traumas during the supervision session.

Session 5: episode 1 (DC). The client stimulus involved discussion of client's health concerns. The client vehemently corrected the counsellor when she described MS as "your disease." The counsellor reported this incident of experiencing correction by the client as challenging in her session notes.

Session 7: episode 1 (DC). The client stimulus involved discussion of the client's dream about death earlier in the session. The counsellor did not process the dream. Later in

the session the client discussed feeling sad and depressed. The counsellor noted they had not processed the dream. The counsellor reported feeling challenged by the dream in her session notes and during supervision.

Session 3: episode 2 (IC). The client stimulus involved the following themes: depression, emotional arousal (crying, sad, angry), and helplessness. The counsellor reported themes of helplessness in her session notes. During supervision she reported that she found sitting with the client's feelings of helplessness and depression difficult. Ratings by the counsellor and the supervisors of the counsellor's reactivity to various client issues and presentation styles identified depression and emotional arousal (sadness, anger) as "slightly to quite difficult" and helplessness and lack of control as "somewhat to quite difficult".

Session 3: episode 4 (IC). The client stimulus involved the following themes: personal stress regarding health concerns, helplessness, emotional arousal (crying, sad, and powerful). In her session notes, the counsellor reported that she lacked a framework to support the client in managing her disease. During supervision she reported a sense of helplessness regarding the client's medical issues. Ratings by the counsellor and the supervisors of the counsellor's reactivity to various client issues and presentation styles identified personal stress, health concerns, and emotional arousal (sad) as "slightly to somewhat difficult" and helplessness and lack of control as "somewhat to quite difficult".

Session 4: episode 1 (IC). The client stimulus included discussion of the client's health history and feelings of helplessness. The counsellor referred to perfectionism in her response. In the session notes, the counsellor reported that she felt she supported and validated the client throughout the session. During supervision the counsellor reported feeling challenged by the client's feelings of helplessness. She also identified perfectionism as a challenge for her working with this client. Ratings by the counsellor and the supervisors of the counsellor's reactivity to various client issues and presentation styles identified physical health as "slightly difficult" and perfectionism and helplessness as "somewhat difficult".

Session 4: episode 2 (IC). The client stimulus contained the following themes: family of origin (mother), physical health, sadness, crying, lack of control, and helplessness. In the session notes, the counsellor reported that she felt she supported and validated the client throughout the session. During supervision the counsellor reported feeling challenged by the

client's feelings of helplessness regarding medical concerns. She found it difficult to stay with client's emotional expression and not move into a problem-solving mode. She also noted she identified with the client's mother issues. Ratings by the counsellor and the supervisors of the counsellor's reactivity to various client issues and presentation styles identified parents, physical health, helplessness, lack of control, and sadness as "slightly to somewhat difficult".

Session 5: episode 2 (IC). The client stimulus included discussion of the client's health concerns and how they have forced her to face her reality. She wondered whether she had "manifested" help when she needed it most (e.g., in reference to the counsellor). In the session notes, the counsellor noted that this part of the session "went well" whereas the judges rated the counsellor's responses as under-involved. During supervision the counsellor noted she often felt the urge to "fix" the client's health concerns. The counsellor reported that loss of control and helplessness was challenging for her to deal with. Ratings by the counsellor and the supervisors of the counsellor's reactivity to various client issues and presentation styles identified physical health as "slightly difficult" and helplessness and lack of control as "somewhat to quite difficult".

Session 5: episode 3 (IC). The client stimulus included themes of personal stress and references to death. The client was powerful in her presentation style. The counsellor reported that this section of the session "went well" in her session notes, whereas the judges rated the counsellor's response as over-involved. During supervision she related that she found sitting with depression, the client's feelings of hopelessness, helplessness, and loss of control challenging. Ratings by the counsellor and the supervisors of the counsellor's reactivity to various client issues and presentation styles identified personal stress and death "slightly to somewhat difficult" and helplessness, lack of control, and powerful interpersonal style as "somewhat to quite difficult".

Session 6: episode 1 (IC). Client stimulus involved discussion of a medical terminology course that the client found upsetting because of its reference to MS as a progressive degenerative disease. Themes of physical health, loss or control, and emotional arousal (sad, scared, mad, crying) were addressed. The counsellor described the incident regarding the course as upsetting for the client in her session notes. During supervision the counsellor reported feeling challenged to stay with the client's feelings and not move into a

problem-solving mode. She also reported loss of control and helplessness challenging. Ratings by the counsellor and the supervisors of the counsellor's reactivity to various client issues and presentation styles identified anger, sadness, and fear as "slightly to quite difficult" and lack of control and helplessness as "slightly to somewhat difficult".

Session 6: episode 2 (IC). The client stimulus involved a continuation of the discussion regarding the medical terminology course. Themes of physical health, loss of control, and emotional arousal (fear, anger, and power) were addressed. The counsellor described the incident regarding the course as upsetting for the client in her session notes. During supervision the counsellor reported feeling challenged to stay with the client's feelings and not move into a problem-solving mode. She also reported that loss of control and helplessness was challenging for her to deal with. Ratings by the counsellor and the supervisors of the counsellor's reactivity to various client issues and presentation styles identified anger, fear, and power as "slightly to quite difficult" and lack of control and helplessness as "slightly to somewhat difficult".

Session 6: episode 3 (IC). The client stimulus included discussion of a course that the client was facilitating. She described working to make the class positive for students, unlike her own experiences as a student (reference to the medical terminology course in episodes 1 and 2). The counsellor described the incident regarding the medical course as upsetting for the client in her session notes. During supervision the counsellor reported feeling challenged to stay with the client's feelings and not move into a problem-solving mode to "fix it". She also reported that the client's lack of control and helplessness was challenging. Ratings by the counsellor and the supervisors of the counsellor's reactivity to various client issues and presentation styles identified lack of control and helplessness as "slightly to somewhat difficult".

Direct and Indirect Confirmation: Counsellor Two

Based on the data converged in Table 7 the episodes that received direct and indirect confirmation for the triggers are summarized for Counsellor Two. Episodes with direct confirmation (DC) are presented first, followed by those that received indirect confirmation (IC). For the episodes that received direct confirmation (e.g., DC), only the datum source that included direct support for the potential trigger(s) in the client stimulus is reported below.

For the episodes that received indirect confirmation (e.g., IC), all the data sources that supported the potential trigger(s) in the client stimulus are included below.

Session 3: episode 6 (DC). The client stimulus involved the client self-disclosing that one of her older brothers had sexually abused her as a child. The counsellor reported in the session notes that the issue of the client's abuse was challenging to deal with. He noted that he felt as if he wanted revenge on the client's behalf.

Session 3: episode 7 (DC). The client stimulus involved discussion of the client's sexual abuse and younger brother's accidental death. The counsellor and client were completing a genogram. The client presented as sad and tearful. The counsellor reported in the session notes that he found the discussion about the client's brothers challenging. He felt drawn into problem-solving and wanting revenge.

Session 4: episode 1 (DC). The client stimulus included the counsellor asking the client how she felt they were doing in terms of developing strategies to deal with her anxiety. The client related that she did not feel they had not made any progress. The counsellor identified the client's denial of progress as challenging in his session notes, during supervision, and in his post-session ratings.

Session 4: episode 2 (DC). The client stimulus involved discussion about how the client has dealt with anxiety in the past. The client described an extremely difficult period of her life. The counsellor reported in his session notes that he felt "clumsy" in working with how the client previously dealt with anxiety. This episode followed shortly after the client's denial of progress in therapy (see session 4: episode 1).

Session 4: episode 3 (DC). The client stimulus included a continuation of the discussion on how the client dealt with anxiety. The client had reported an experience in which her ex-boyfriend had threatened her life at knife point. As referenced above (see session 4: episode 2), the counsellor reported in his session notes that he felt "clumsy" in working with how the client previously dealt with anxiety. This episode followed shortly after the client's denial of progress in therapy (see session 4: episode 1).

Session 5: episode 2 (DC). The client stimulus involved discussion of the client's experience of sexual abuse by her older brother. The counsellor reported the discussion of sexual abuse as challenging in his session notes.

Session 3: episode 1 (IC). The client stimulus included themes of physical health, self-esteem, and family of origin. The client related how previous therapy had helped her work on assertiveness. In the session notes the counsellor stated that he decided to write notes during the session to keep focused because he found his "mind wandering" in the previous sessions trying to problem-solve. He noted the client's conflictual family relationships in his session notes and in supervision. During supervision the counsellor reported that he liked to use notes for structure. The clinical research supervisor noted that the counsellor did not seem comfortable sitting with the client's process without a clear direction. Ratings by the counsellor and the supervisors of the counsellor's reactivity to various client issues and presentation styles identified self-esteem, parents, and siblings as "slightly to somewhat difficult" and physical health as "somewhat to quite difficult".

Session 3: episode 2 (IC). The client stimulus included the following themes: family of origin, self-esteem, depression, and alcoholic ex-partner. The references from the session notes and supervision notes are the same as above (see session 3: episode 1). Ratings by the counsellor and the supervisors of the counsellor's reactivity to various client issues and presentation styles identified self-esteem, parents, and siblings as "slightly to somewhat difficult," depression and substance abuse as "somewhat difficult," and ex-partner as "slightly to quite difficult".

Session 3: episode 3 (IC). The client stimulus involved discussion of the client's chaotic experiences in her family including a brief reference of sexual abuse by her brother. She reported it was difficult for her to get mad in her family and her experiences resulted in her feeling unworthy. The counsellor referred to the client's conflictual family relationships in his session notes and during supervision. He also noted that it was a challenge for him to deal with anger in his own life. Ratings by the counsellor and the supervisors of the counsellor's reactivity to various client issues and presentation styles identified parents, siblings, and self-esteem as "slightly to somewhat difficult" and sexual abuse and anger as "somewhat to quite difficult".

Session 3: episode 4 (IC). The client stimulus involved themes of physical health concerns and self-esteem. The counsellor had asked the client how they were doing in terms of the initial goals she came to counselling with. The references from the session notes and supervision notes focus on the counsellor's desire for structure and problem solving (see

session 3: episode 1). Ratings by the counsellor and supervisors of the counsellor's reactivity to various client issues and presentation styles identified self-esteem and physical health concerns as "somewhat to quite difficult".

Session 3: episode 5 (IC). The client stimulus included discussion about the client's recent complications from her hysterectomy operation that almost resulted in her death. Themes of personal stress and anger towards her niece also emerged. In the session notes the counsellor noted the client's anger towards her niece and reported that the client has experienced two life-threatening episodes – an abusive relationship and blood clots from the operation. During supervision the counsellor reported the client's chaotic family of origin. He also related that it is a challenge for him to deal with anger in his own life. Ratings by the counsellor and supervisors of the counsellor's reactivity to various client issues and presentation styles identified personal stress as "slightly to somewhat difficult," death as "somewhat difficult," and physical health concerns and anger as "somewhat to quite difficult".

Session 3: episode 8 (IC). The client stimulus included the following themes: family of origin, sexual abuse, and emotional arousal (sad and angry). In the session notes the counsellor reported that the client was visibly upset. He felt like he wanted revenge against the client's brother (who had abused her). The counsellor went overtime in the session to deal with the sensitive issue the client brought up. During the supervision session, the counsellor reported that he usually goes over-time in the session. He noted the theme of anger in relationships for the client. The counsellor acknowledged it was a challenge for him to deal with anger in his own life. Ratings by the counsellor and supervisors of the counsellor's reactivity to various client issues and presentation styles identified sadness and sibling issues as "slightly to somewhat difficult" and sexual abuse and anger as "somewhat to quite difficult".

Session 4: episode 4 (IC). The client stimulus involved discussion of the client's level of anxiety. The counsellor asked the client the "miracle question." In the session notes the counsellor reported he thought the "miracle question" was successful. The judges rated this section as over/under-involved. Earlier in the session he reported feeling surprised when the client stated that they had not made much progress in terms of dealing with anxiety (see session 4: episode 1). During supervision the counsellor reported that he liked to use notes

for structure. The clinical research supervisor noted that the counsellor liked to have structure available – he did not seem comfortable sitting with the client's process without a clear direction. Ratings by the counsellor and the supervisors of the counsellor's reactivity to various client issues and presentation styles identified anxiety as "slightly to somewhat difficult".

Session 5: episode 1 (IC). The client stimulus involved discussion of physical health issues and medication. The client presented as worried and sad. The counsellor asked the client if she had completed the homework (e.g., miracle question). The client related that she had not completed the exercise because she felt ill. The counsellor switched the focus to gathering further information regarding the client's family of origin. The counsellor reported in the session notes that he felt awkward during the session because he was uncertain about the amount of progress they were making. The reference from the supervision notes is the same as above (see session 4: episode 4) – the counsellor and the supervisor reported the counsellor's preference for structure. In addition, the counsellor noted that he felt he should know more about medications, but was staying out of that "trap." Ratings by the counsellor and the supervisors of the counsellor's reactivity to various client issues and presentation styles identified emotional arousal (sad and worried/scared) as "slightly to somewhat difficult" and physical health and medication as "somewhat to quite difficult".

Session 5: episode 3 (IC). The client stimulus included themes of family of origin and physical health. The counsellor was taking notes about the client's family when he noticed she was rubbing her arm. They returned to information gathering after the client confirmed that she was not cold, but her arms were sore from her arthritis and surgery. The reference from the session notes is the same as above (session 5: episode 1) – the counsellor reported feeling awkward during the session. The reference from the supervision notes is also the same as in other episodes (e.g., session 4: episode 4) – the counsellor and supervisor reported the counsellor's preference for structure. Ratings by the counsellor and the supervisors of the counsellor's reactivity to various client issues and presentation styles identified parents and siblings as "slightly to somewhat difficult" and physical health as "somewhat to quite difficult".

Session 6: episode 1 (IC). The client stimulus included the following themes: physical health, medication, emotional arousal (scared and sad), and personal stress. The client was

describing how her doctor had to change her medication because of damage to her heart muscle. The counsellor was trying to write down all the medication names. In the session notes the counsellor reported that the client was experiencing difficulty with her heart. He had prepared an agenda prior to the session and had hoped for some "positive breakthroughs" during the session. During supervision the counsellor and supervisor noted his preference for structured activities during session. The counsellor was less comfortable with a non-directive process. Also, the counsellor related that he felt he should know more about medications. Ratings by the counsellor and the supervisors of the counsellor's reactivity to various client issues and presentation styles identified personal stress and emotional arousal (sadness and fear) as "slightly to somewhat difficult" and physical health and medication as "somewhat to quite difficult".

Session 6: episode 2 (IC). The client stimulus involved personal stress. The client felt overwhelmed by the clutter in her home and lacked the energy to do anything about it. The counsellor was trying to encourage her to think of ideas to address the clutter. The counsellor referred to the discussion of "clutter" in his session notes. He felt the exploration "went well," but the judges rated the episode as over/under-involved. The counsellor was hoping to discover strategies to help the client deal with her anxiety. During supervision the counsellor and supervisor noted his preference for structured activities during sessions. The counsellor was less comfortable with a non-directive process. Ratings by the counsellor and the supervisors of the counsellor's reactivity to various client issues and presentation styles identified personal stress and anxiety as "slightly to somewhat difficult".

Session 6: episode 3 (IC). The client stimulus involved discussion of family of origin issues (client's sister) and physical health concerns. The client was frustrated and angry about her sister's failure to ask the client how she is doing or whether she requires any assistance. If her sister promises to help with a task, she never follows through. The counsellor recommended that she find someone else to help her. In the session notes, the counsellor reported that he felt he and the client understood each other well regarding her sister. The judges rated this episode as over-involved. During supervision the counsellor and supervisor noted his preference for structured activities during sessions. The counsellor was less comfortable with a non-directive process. Ratings by the counsellor and the supervisors of the counsellor's reactivity to various client issues and presentation styles identified personal

stress and siblings as "slightly to somewhat difficult" and physical health and anger as "somewhat to quite difficult".

Session 6: episode 4 (IC). The client stimulus involved discussion of the client's difficulty "letting go of people and things." The counsellor was trying to get the client to think of exceptions to the rule. He pointed out that she had "let go" of her ex-partner. The client stated that her ex-partner had died so she had had no choice. In the session notes and during supervision, the counsellor emphasized his desire for a positive outcome during sessions. He preferred a structured style and did not seem comfortable sitting in the process. The counsellor reported during supervision that he frequently asked, "how would you recognize strategies". Ratings by the counsellor and the supervisors of the counsellor's reactivity to various client issues and presentation styles identified personal stress and self-esteem as "slightly to somewhat difficult" and ex-partner as "quite difficult".

Session 6: episode 5 (IC). The client stimulus involved a continuation of the discussion about the client's relationship with her sister, who lives in the same apartment building. The client expressed feeling angry and fed up with her sister's selfish attitude. In the session notes, the counsellor reported that he felt he and the client understood each other well regarding her sister. The judges rated this episode as over-involved. Again, in the session and supervision notes the counsellor focused on trying to identify strategies to deal with the client's anger. The counsellor reported that dealing with anger was a challenge in his own life in the supervision session. Ratings by the counsellor and the supervisors of the counsellor's reactivity to various client issues and presentation styles identified personal stress and siblings as "slightly to somewhat difficult" and anger as "somewhat to quite difficult".

TABLE 6

Counsellor 1 Episodes of Over and Under Involvement

Client Stimulus/Triggers	Counsellor Verbalizations/Response	Session Notes	Supervision	Ratings*
COUNSELLOR 1: SESSION 3				
EPISODE 1				
Loss of bowel movement at a party. Client crying and upset. (Physical health, personal stress, loss of control, sad)	Under-involvement: "I was just going to ask you about that. You know I'm aware of this too, this um.... Overall in terms of the disease I don't know what that means."	Counsellor feels lack of framework to support client managing the disease. Reported critical incident of loss of bowel control. (direct reference)	Counsellor reports sense of helplessness re: medical concerns. Counsellor reports feeling challenged to stay with feelings and not go into head/cognitive mode.	-Helplessness 2/3 (RS, CO) -Personal Stress 1/2/2 (RS, PS, CO) -Chronic pain 2/3 (PS/CO) -Lack of Control 3 (CO) -Sad 1/2 (RS,CO)
EPISODE 2				
Client is overwhelmed by friend's health concerns in addition to her own. Client crying and upset. (Depression, financial constraints, sad, angry, helplessness"	Under-involvement: "Well one thing about depression is that it makes you sit still for a while, so"	Counsellor noted themes lack of control and helplessness	Counsellor found sitting with client's feelings of helplessness and depression difficult.	-Helplessness 2/3 (RS/CO) -Personal stress 1/2/2 (RS, PS, CO) -Lack of control 3 (CO) -Depression 1/2/2 (PS, RS, CO) -Sad 1/2

Client stimulus/Triggers	Counsellor Verbalizations/Response	Session Notes	Supervision	Ratings*
				(RS, CO) -Mad 1/3 (PS/CO)
EPISODE 3 Mother and Aunt's attempted suicide in the past Client witnessed mother's attempt as a child. Sense of disbelief at family's expectations. (Depression, suicide, Aunt's breast cancer, death, childhood, adulthood, mad)	Over-involvement: "Never mind they expected you to take her, all her sisters expected you to take her."	Client "mothering her mother". Counsellor noted the client's anger and resentment.	Counsellor reported feeling challenged by discussion of suicide – felt she stumbled. Counsellor identified with the client's "mother stuff" but felt she understood her own issues. (direct reference)	-Suicide 2 (PS, CO) -Death 1/2 (PS, CO) -Childhood 1/2 (PS,CO) -Adolescence 1/2 (PS, CO) -Parents 2/1/1 (PS,RS,CO) -Mad 1/3 (PS/CO)
EPISODE 4 Counsellor asks about self care strategies "who holds you?" Client starts crying. Session goes overtime. Client takes charge of session with information sheets about her health problems. (Helplessness, sad, powerful)	Over-involvement: "I was just thinking, I have a friend with cancer ..." "One of my hesitations is it alright to ask this question?"	Counsellor feels lack of framework to support client managing disease.	Counsellor reported sense of helplessness at times wondering whether she should have deeper understanding of medical issues. "What are we doing?"	-Helplessness 2/3 (RS/CO) -Lack of control 3 (C) -Personal stress 1/2/2 (PS, RS, CO) -Sad 1/2

Client stimulus/Triggers	Counsellor Verbalizations/Response	Session Notes	Supervision	Ratings*
				(RS,CO)
COUNSELLOR 1: SESSION 4 **EPISODE 1** The client was discussing what was going on in her life when she was first diagnosed with MS. She was 26 and had spent a year traveling. She had been listed as a "probable MS" at age 24 because of various symptoms in university (headaches, inflammation of the optic nerve, etc.). Client was relaying history in a neutral "matter of fact" tone. (Physical health, helplessness)	Over-involvement: CO: Because you know, what really strikes me about you is when you talk about your team, too, like you have got – you have really learned how to do this for yourself, like how to get what you need. (A bit later…) CO: Right. So it is like letting go of – when I hear you saying being hard on yourself, I think of perfectionism.	Counsellor reported that she supported and validated client throughout the session.	Counsellor reported she felt challenged by feelings of helplessness at times. She tried to help client make links to deeper issues and to connect with those resources she has. The counsellor could relate to client's issue of "perfectionism" and not wanting help. Counsellor identified perfectionism as one of the challenges for her working with this client.	-Perfectionism 2/2 (RS/CO) -Physical Health 1/1 (PS/CO) -Helplessness 2/2 (RS/CO)
EPISODE 2 The client was discussing how her mother was emotionally unavailable to her while she was growing up. She started crying as she spoke about her experiences. She feels vulnerable, like a child, at times. She	Over-involvement: CO: And knowing where it is safe to fall apart or where it is safe to be who you are. It sounds like with Stewart you have this eight year relationship. So that's one of the places you go. CL: Oh yeah, and he has seen me at the	Counsellor reported that she supported and validated the client throughout the session. Referred to special friend Stewart as her support team in notes	Counsellor reported sense of helplessness re: medical concerns. Counsellor feels challenged to stay with feelings and not go into head/cognitive mode. Counsellor identified	-Parents 2/1/1 (PS/RS/CO) -Physical Health 1/1 (PS/CO) -Helplessness 2/2 (RS/CO)

Client stimulus/Triggers	Counsellor Verbalizations/Response	Session Notes	Supervision	Ratings*
described how she had developed very supportive relationships with her doctor and another male friend, Sean. Client is crying at times during the section. (Mother, physical health, sad, lack of control, helplessness)	very rock bottom. You know he saw me in my last relapse where I was incapacitated once again, he came to my home. He has been to my home many times. To him making a house call is just – he is the old fashioned country doctor. CO: Wow, that's great CO: So you have got some models of male relationships. CL: Fantastic models. CO: Which so many women don't have actually.		with the client's "mother stuff" but felt she understood her own issues.	-Lack of control 2 (CO) -Sad 1/2 (RS/CO) CO: "Tendency at times to want to fix her illness – a reaction also to my own sense of helplessness that I felt at times when the client was struggling with helplessness".
COUNSELLOR 1: SESSION 5 **EPISODE 1** The counsellor and client are discussing physical complications around colitis. Client feeling out of control, like when originally diagnosed with MS. Counsellor said "Your disease" (*) and the client got mad. The conversation shifted to discussing meaning of symptoms such as recent rectal bleeding	Over-involvement: "I mean, I've done some of this reading, too, chakras in your body linked to abuse in your past."	Themes of failure, loss, sense of control. Client wondering if there was a link to past history of abuse… blame someone or something the client could "fix it". The counsellor found it difficult when she said "your" MS and the client vehemently corrected her" (direct reference).	Counsellor noted she feels urge to "fix it" referring to client's health concerns. Found loss of control and helplessness, challenging.	-Helplessness 2/3 (RS/CO) -Lack of control 3 (CO) -Mad 1/3 (PS/CO) -Powerful 2 (CO) "Tendency at times to

Client stimulus/Triggers	Counsellor Verbalizations/Response	Session Notes	Supervision	Ratings*
(Physical health, loss of control, sexual abuse. Client somewhat "cool", angry)				want to fix her illness – a reaction also to my own sense of helplessness that I felt at times when client was struggling with helplessness."
EPISODE 2 Discussing how denial is a luxury the client has not been able to indulge in because her disease has forced her to face reality. She had been in crisis and wondered whether she has "manifested" help when she needed it (e.g. finds this study that offered her counselling). Client is neutral in term of emotions. (Physical health, relationship with counsellor)	Under-involvement: "I had this ...have you heard of ... if you're taking counselling, I don't know if you'll be introduced to this or not, but Maslow ...What is his first name? Starts with an A. He's a psychiatrist. Anyway, he talked about Maslow's hierarchy of needs. It's one of the things we learned about within a triangle."	Counsellor reported that in the client's family of origin, losing control or being vulnerable was not safe, yet through her seeking support of others vis a vis coping with MS she has learned how to reach out in a way that allows her to maintain sense of control to ask for help in a way to get back control. Counsellor found this part of the session "went well", whereas judges rated as Uver-involved.	Counsellor noted she feels urge to "fix it" (referring to client's health concerns). Found loss of control and helplessness challenging.	-Helplessness 2/3 (RS/CO) -Lack of control 3 (CO) -Physical health 1/1 (PS/CO) "Tendency at times to want to fix her illness – a reaction also to my own sense of helplessness that I felt at times when client was struggling with helplessness.
EPISODE 3 Near the end of the session the client was discussing how she tries to take one day at a time because "each day is different". Client is taking somewhat of an	Over-involvement: CL: Surrender is an active choice. It's not passive CO: Yeah. CL: I have learned to define surrender	Counsellor noted themes of loss and sense of control. Linking client's ability to find sense of control as way to surrender, be vulnerable, that is healthy. Counsellor found this part of the session "went well", whereas, judges rates as over-involved.	The counsellor related that sitting with depression, especially client's feeling of hopelessness, challenging.	-Personal stress 2/1/2 (PS,NS,CO) -Helplessness 2/3 (RS/Co) -Lack of control

Client stimulus/Triggers	Counsellor Verbalizations/Response	Session Notes	Supervision	Ratings*
instructor role....taking charge. She stated surrendering (e.g. to death) is an active choice. (Personal stress, death, powerful)	as an active choice that I choose to make sometimes. CO: That's wonderful. Thank you. CL: Hey CO: Yeah, thank you.		Counsellor related this to her own family of origin. She noted that she feels an urge to fix it. Found loss of control and helplessness challenging.	3 (CO) -Powerful (2) (CO) -Death 1/2 (PS,CO) "Tendency at times to want to fix ....)
COUNSELLOR 1: SESSION 6 **EPISODE 1** Client discussing experience in a medical terminology class where instructor described MS as a progressive degenerative disease. The client did not want to lose control in the class. At the end she went to her car and cried. Client upset and crying. (Physical health, losing control, fear, sad, mad)	Over-involvement: "So I mean, I was getting irritated just listening to that, like da da da da da da and here you are like he has no idea who's in his class?"	Issue with instructor at college teaching about medical conditions. Brought up issues of fear, denials, anger in client.	Found loss of control and helplessness challenging. The counsellor reports feeling challenged to stay with feelings and not go into head/cognitive mode.	-Mad 1/3 (PS/CO) -Scared 1/2/1 (PS/RS/CO) -Sad ½ (Rs/Co) -Lack of control 2/3 (CO) -Helplessness 2/2 (RS/CO) "Perhaps I have an idea that we can be "fixed" or changed emotionally but working with chronic illness is often about

Client stimulus/Triggers	Counsellor Verbalizations/Response	Session Notes	Supervision	Ratings*
				coping with helplessness."
EPISODE 2 Counsellor and client continued discussion regarding experience with instructor. Brought up feelings of fear and anger that at any moment life could be taken away again. Client fights fears by helping others fight (e.g. facilitating course for others with illness). Client was considering talking to instructor about her situation. (Physical illness, loss of control, fear, anger, power)	Over-involvement: "Yeah. You know, I just want you to know some things about this too, because it is a situation – there's always this power imbalance when you've got a teacher and a student, too, whether you think that or not, it's my experience, it's odd 'cause I'd had a career…"	Issue with instructor at college teaching about medical conditions. Brought up issues of fear, denial, anger in client.	Found loss of control, helplessness and challenging. The counsellor reports feeling challenged to stay with feelings and not go into head/cognitive mode.	-Mad 1/3 (PS/CO) -Scared 1/2/1 (PS/RS/CO) -Power 2 (Co) -Lack of control 2/3 (CO) -Helplessness 2/3 (RS, CO)
EPISODE 3 The client is discussing her experience as an instructor to people who have health concerns. She is trying to make students feel comfortable, unlike her own experiences as a student. (Neutral tone, helplessness, lack of control)	Over-involvement: "Sounds like you choose your battles and you haven't … what I heard you say, too, 'cause I don't want to let this go, sounds like you still want to say something to that instructor, sounds like you're looking for a way to do that."	Issue with instructor at college teaching about medical conditions. Brought up issues fear, denial, anger in client.	Found loss of control and helplessness challenging. She noted she feels urge to "fix it" The counsellor reports feeling challenged to stay with feelings and not go into head/cognitive mode	"Tendency at times to want to fix .." -Lack of control 2/3 (CO) -Helplessness (2/3) (RS/CO)

Client Stimulus/Triggers	Counsellor Verbalizations/Response	Session Notes	Supervision	Ratings*
COUNSELLOR 1: SESSION 7 **EPISODE 1** Client reports dreams at beginning of session. She is crying while she describes dream. Client in box-coffin. She is going to dies and she hasn't said good-bye to everyone she wants to. (Appendix 4, line 921) Near end of session client is discussing how she has been feeling depressed, sad, tired. The conversation moves to strategies and the client refers to the class she is teaching. (Sad, death, fear, depression, helplessness)	Over-involvement "Umm, I can't help but say this, when you were talking about references, at the end of this class, I hope you get some testimonials". A few talking turns later: "I'm thinking about where we started today 'cause you were in the dream, in subconscious and in vulnerability and I don't feel like we really did the dream, I don't know if we – I don't know if you want to"	Counsellor noted that processing the dreams started out in the present tense – but got away from it. She felt less effective in the sense of letting the dream go – versus processing it. Counsellor wondered if she found it difficult to "stay with" the dream because of her own parallel process of also waking up out of an intense dream. Counsellor reported it was difficult to stay in depression. She wanted to break silence and talk – move away from depression. (direct reference)	Counsellor found sitting with client's feelings of helplessness and depression difficult. She noted that she feels the urge to fix it. The counsellor also noted a "critical incident" relating to a dream the client brought to one session. The counsellor described feeling a parallel process, in that she also had a dream. She did not explore the dreams in depth and later wondered why. (direct reference)	-Depression 1/2/2 (PS/NS/CO) -Death 1/2 (PS/CO) -Sad 1/2 (RS/CO) -Helplessness 2/3 (RS/CO) "tendency at times to want to fix her illness –"

* Rating scale ranged from 0 (not at all difficult), 1 (slightly difficult), 2 (somewhat difficult), 3 (quite difficult) to 4 (extremely difficult)
PS= Previous Supervision; RS = Research Supervisor; CO = Counsellor

TABLE 7

Counsellor 2 Episodes of Over and Under Involvement

Client Stimulus/Triggers	Counsellor Verbalizations/Responses	Session Notes	Supervision	Ratings*
COUNSELLOR 2: SESSION 3 **EPISODE 1** The client was discussing how she has been trying to be more assertive and not worry what others particularly her family, thinks. Through the help of previous therapy, she realizes that she is changing but that others "aren't happy" with the changes. In the past she would drop everything to help others, but because of her rheumatoid arthritis she has had to take better care of herself. The client is talking eagerly about her self-discoveries. (Physical Health, self-esteem, family of origin)	Over-involvement: CO: So they are the changing roles. Okay one of the things I wanted to sort of touch on— CL: Yeah. CO: -- in our talk today was to check whether we are on track and you know, your goal initially when you came here was to find ways to deal with the anxiety associated with the … that's been building for years.	Counsellor reported in notes from session 1 and 2 that "his mind was wandering" and searching for ways to work with the client's challenges. He was getting into problem solving. He reported that he often forgot key words, phrases, or expressions that she used (Session 2). As a result, in session 3, the counsellor used a clipboard to write notes. "In this session, I used my notes and asked questions for her to amplify on decision making". Counsellor noted conflictual family relationships.	Counsellor made detailed notes before/after sessions and also during. He noted that he liked to use the notes for structure – a burst of structure then sit back for a few moments. The research supervision noted that the counsellor like to have structure available (e.g. genogram, solution-focused strategies) and sometimes didn't seem comfortable with process-sitting with client without clear direction. Client has fused family of origin, very conflictual and chaotic.	-Self-Esteem 1/1/2 (PS/RS/CO) -Physical Health 3/2 (PS/CO) -Parents 1/2/1 (PS/RS/CO) -Siblings 2/1 (PS/CO)
EPISODE 2 The counsellor and client were discussing the client's family of origin. She was one of 7 children and grew up in	Over/under –involvement: CO: Yeah .So all right. I have made some notes for myself because I am still in the studying phase very much	Counsellor reported in notes from session 1 and 2 that "his mind was wandering" and searching for ways to work with the client's challenges. He was getting into problem solving.	Counsellor made detailed notes before and after sessions and also during. He noted that he liked to	-Parents 1/2/1 (PS/RS/CO) -Siblings 2/1

Client Stimulus/Triggers	Counsellor Verbalizations/Response	Session Notes	Supervision	Ratings*
Scotland. She was taught by her mother to cater to other's needs. Her mother was depressed for which she never received treatment. The client felt that she was trained to over-extend herself for others to the point that her life was chaotic. She became involved with a violent alcoholic man for years. Client's emotional tone neutral. (Family of origin, self-esteem, depression, ex-partner, substance abuse)	and developing	He reported that he often forgot key words, phrases, or expressions that she used (Session 2). As a result, in session 3, the counsellor used a clipboard to write notes. "In this session, I used my notes and asked questions for her to amplify on decision making". Counsellor noted conflictual family relationships.	use the notes for structure – a burst of structure then sit back for a few moments. The research supervisor noted that the counsellor liked to have structure available (e.g. ? solution focused strategies) and sometimes didn't seem comfortable with process – sitting with client without a clear direction.	(PS/CO) -Depression 2/2 (PS/CO) -Ex-partner 3/1 (PS/CO) -Substance Abuse 2/2 (PS/CO) -Self-Esteem 1/1/2 (PS/RS/CO)
EPISODE 3 The client was discussing how her upbringing was chaotic and she was always trying to please everyone so they wouldn't get mad. She mentioned that one of her older brothers had sexually abused her and that she grew up frightened of him. She was popular with her peers and this popularity continued into the workforce. Although she had a facade of	Over-involvement CL: I had a persona of confidence you know, I was friendly, outgoing, blah, blah, blah people pleaser type, but when it came to the crunch, exams or anything I just – I lost it. CO: Yeah, I actually can relate to that myself. CL: Oh. CO: I felt I was being a – you know there was a lot expected of me, I had this expectation of what wad expected	Counsellor noted conflictual family relationships	Fused family of origin, very conflictual, chaotic. Challenge for counsellor to deal with anger in his own life.	-Parents 1/2/1 (PS/RS/CO) -Siblings 2/1 PS/CO -Self-esteem 1/1/2 (PS/RS/CO) -Sexual Abuse 3/2/2 (PS/RS/CO) -Mad PS/RS/CO

Client Stimulus/Triggers	Counsellor Verbalizations/Response	Session Notes	Supervision	Ratings*
confidence, she felt she was unworthy under the surface. Client tone as neutral, talkative. (Family of origin, sexual abuse, self-esteem, fear, mad)	of me. So anyway....			
EPISODE 4 The counsellor asked the client how they were doing in terms of the initial goal she came in with. She had been discussing how she was trying to shift her thinking from "negative" to "positive". She also discussed how she has had to adjust her expectations given her health concerns. (Health concerns, self-esteem)	Under-involvement CO: How are we doing in terms of the goal that you came I with – the rheumatoid arthritis and how it affects your life. Maybe we are going off track, I am just trying to do sort of a check.	Counsellor reported in notes from session 1 and 2 that "his mind was wandering" and searching for ways to work with the client's challenges. He was getting into problem solving. He reported that he often forgot key words, phrases, or expressions that she used (Session 2). As a result, in session 3, the counsellor used a clipboard to write notes. "In this session, I used my notes and asked questions for her to amplify on decision making".	Counsellor made detailed notes before/after sessions and also during. He noted that he liked to use the notes for structure – a burst of structure then sit back for a few moments. The research supervision noted that the counsellor like to have structure available (e.g. genogram, solution-focused strategies) and sometimes didn't seem comfortable with process-sitting with client without clear direction.	-Physical Health 3/2 (PS/CO) -Personal Stress 1/2 (PS/CO)
EPISODE 5 Client was discussing how the complications from her hysterectomy (blood clots) had been serious and she almost	Under-involvement: CO: So in a way this healing of yours is –	Counsellor reported that the client felt some anger towards her niece for having put friend's needs before hers. There had been two life threatening episodes: abusive relationship with	Fused family of origin, very conflictual, chaotic. Challenge for counsellor to deal	-Physical Health 3/2 (PS/CO) -Mad 3/2/2

Client Stimulus/Triggers	Counsellor Verbalizations/Response	Session Notes	Supervision	Ratings*
died. She realized that she had not been taking care of herself and that she had to start being more careful. She knew she would not get better by positive thinking alone. The client also felt annoyed by her niece who was putting her friend's needs before the client's. (Physical health, personal stress, death, mad)	CL: Yeah, it has been a catharsis CO: -- is a catharsis, but also it is now – you are really working with it and actually in a way you can pass what you are learning on to – CL: Yeah, to my niece CO: -- to Julie, right. That's great, yeah.	ex-boyfriend and recent blood clots after operation.	with anger in own life.	PS/RS/CO -Personal Stress 1/2 (PS/CO) -Death 2/2 (PS/CO)
EPISODE 6 The client was discussing how her desire to be more assertive has brought her to the point that she wants to confront her older brother (the one who sexually abused her) regarding their family home in Ireland which he occupies and the rest of the siblings want to sell. She was hoping to plan a trip to Ireland with her sisters to address selling the family home. She was angry that he has controlled all of the siblings.		Client revealed which brother had abused her and was clearly angry at him. Counsellor reported feeling himself being drawn into problem solving and wanting revenge. (direct reference)	Fused family of origin, very conflictual, chaotic. Challenge for counsellor to deal with anger in own life.	-Siblings 2/1 (PS/CO) -Self-esteem 1/1/2 (PS/RS/CO) -Anger/Mad 3/2/2 (PS/RS/CO) -Sexual Abuse 3/2/2 (PS/RS/CO)

Client Stimulus/Triggers	Counsellor Verbalizations/Response	Session Notes	Supervision	Ratings*
(Siblings, sexual abuse, self-esteem, mad)				
EPISODE 7 The counsellor had introduced the idea of doing a genogram. They were involved in this process. The client was discussing one of her brothers, Bill, who had drowned while drunk. She related how the older brother, John who had abused her, was also cruel to her brother, Bill, who died. Client was angry, holding back tears. Quiver in her voice. (Sibling's death, sexual abuse, sad)	Under-involvement CL: And he didn't drown really, he got scalded to death in the tub, he was drunk. CO: Okay CL: But now we are hearing John was there and John didn't treat Bill very well. CO: Well, I didn't know where this was going to go, but there is… CL: Yeah. I really hate John. I don't hate people usually, I am not a hateful person. CO: I can see…	Client clearly angry with her brother who abused her. When the counsellor heard about the two brothers lives (one deceased) he felt himself being draw into problems solving and wanting revenge. (direct reference)	Counsellor made detailed notes before/after sessions and also during. He noted that he liked to use the notes for structure – a burst of structure then sit back for a few moments. The research supervision noted that the counsellor like to have structure available (e.g. genogram, solution-focused strategies) and sometimes didn't seem comfortable with process-sitting with client without clear direction. Client has fused family of origin, very conflictual and chaotic. Challenge for counsellors to deal with anger in own life.	-Siblings 2/1 (PS/CO) -Death 2/2 (PS/CO) -Sexual Abuse 3/2/2 (PS/RS/CO) -Sad 1 (PS/RS/CO)
EPISODE 8 The counsellor and client	Under-involvement:	Client clearly angry with her	Clients reported that he	-Mad

Client Stimulus/Triggers	Counsellor Verbalizations/Response	Session Notes	Supervision	Ratings*
were near the end of the session, completing the genogram and talking about brother John. The client was emotional as she felt they had "opened up" her life during the session. (Sad, Angry, Sibling, Sexual Abuse)	(Session is over time) CL: I am actually afraid of my anger because I have always suppressed anger, I have never allowed it to – CO: I think you are thinking of John here. CL: M'hm CO: Well, I think we need to stop here. (session goes on for 10 minutes)	brother who abused her. when I heard about the two brothers lives (one deceased) I felt myself being drawn into problem solving and wanting revenge. Counsellor extended session to deal with sensitive context brought up. Counsellor noted that the client is noticeably upset.	usually goes over-time in the sessions – boundary issue. Theme of anger in relationships for the client. Counsellor noted that it is a challenge for him to deal with anger in his own life.	3/2/2 (PS/RS/CO) -Sad 1 (PS/RS/CO) -Siblings 2/1 (PS/CO) -Sexual Abuse 3/2/2 (PS/RS/CO)
COUNSELLOR 2: SESSION 4 **EPISODE 1** Client was discussing how she had been very tired and had fallen asleep while reading the newspaper. She was uncertain about the reason – change in medication, or just overtired. She was speaking in a matter of fact manner. Sleep has been a problem for her lately. Counsellor asked her how she thought they were doing in terms of developing ways to deal with her anxiety. She responded by saying she didn't think they had	Over-involvement: CO: I am aware for myself I haven't sort of investigated that in as much detail as I think we should have done together, you know, I know we are finding ways to deal with the anxiety, so – yeah, so far the things that have come up have been as a result of talking about what's happened over the week – CL: Yeah. CO: - and so on. Well, you see counselling is a process, I can't see inside – CL: No	Counsellor felt surprised where client felt they had not made much progress in terms of developing strategies to deal with anxiety. (direct reference)	Reported that he was taken aback when he asked client whether they were meeting treatment goals and she said "no".	-Anxiety 1/1/2 (PS,RS,CO) -Personal Stress 1/2 (PS, CO) -Physical Health 3/2 (PS,CO) -Medication 2 (RS) "Was there anything about this client's experience that you found difficult to work with?" In session 4 she said she felt we had not

Client Stimulus/Triggers	Counsellor Verbalizations/Response	Session Notes	Supervision	Ratings*
tackled anything yet. Client tone neutral. (Anxiety, personal stress, medication)	CO: Your mind....			made any progress in developing strategies for dealing with her anxiety. I felt stumped for a while (reported at tend of all sessions).
EPISODE 2 Shortly after Episode 1, the client and counsellor are exploring how client has dealt with anxiety and fear. She described how it was difficult for her to ask for help. She relayed past experiences of living with an alcoholic boyfriend and struggling with rheumatoid arthritis. One day her doctor asked about stress in her life and the client "opened the floodgates". Client tone neutral. (Ex-partner, physical health, anxiety, personal stress)	Over-involvement CO: So did you ask for help? CL: Well, I answered his questions, I didn't ask for help. CO: Okay. So there is a little interesting thing here, what is – I mean for me – so let's just talk about his, and I am feeling my way through this, believe me. CL: Yeah.	Counsellor felt surprised where client felt they had not made much progress in terms of developing strategies to deal with anxiety. Counsellor reported feeling "clumsy" in working with how client previously dealt with anxiety and how she saw healing. (direct reference)	Counsellor reported that he was taken aback when he asked client whether they were meeting treatment goals and she said "no".	-Ex-partner 3/3 (PS/CO) -Physical Health 3/2 (PS/CO) -Personal Stress 1/2 (PS/CO) -Anxiety 1/1/2 (PS/RS/CO) "Was there anything about this client's experience..."
EPISODE 3 The client was describing how stressful her relationship with her ex-boyfriend was. She felt responsible for him and it was difficult for her to leave him. He threatened her with a knife one	Over/under-involvement: CO: ...so in a way that calmative process is healing. CL: Well, I think I am healing now from it, I don't think I was healing then, I think it was like coming to a	Counsellor felt surprised where client felt they had not made much progress in terms of developing strategies to deal with anxiety. Counsellor reported feeling	Reported that he was taken aback when he asked client whether they were meeting treatment goals and she said "no".	-Ex-partner 3/3 (PS/CO) -Personal Stress ½ (PS/CO) -Anxiety 1/1/2

Client Stimulus/Triggers	Counsellor Verbalizations/Response	Session Notes	Supervision	Ratings*
occasion. The doctor (referred to in Episode II) had referred her to a social worker for help (continuation of discussion on how to deal with anxiety). Client tone slightly irritated. (Ex-partner, personal stress, violence/death)	head. CO: I think the more – I think—we are looking for ways of dealing with anxiety. CL: Yeah. CO: So I went and called so … so call that healing. CL: A healing process, yeah. CO: Healing process.	"clumsy" in working with how client previously dealt with anxiety and how she saw healing. (direct reference)		(PS/RS/CO) -Mad 3/2/2 (PS/RS/CO) -Self-esteem 1/1/2 (PS/RS/CO) "Was there anything about this client's experience…"
EPISODE 4 The counsellor was asking the client to rate her level of anxiety on a scale of 1 to 10 comparing when she started the counselling sessions and during today's session. He also asked the client the "miracle question" (If a miracle happened what would be different). Client tone neutral. (Anxiety)	Over/under-involvement: CO: Okay. That's a very useful way of sort of seeing – CL: Gauging. CO: Gauging, yeah, for both of us. So that's good, so that's an increase. It is not – it is not ten, but you have come two points – CL: That's right. CO: -- on the scale. CL: That's right. CO: And all we have done is sat and	Counsellor felt surprised where client felt they had not made much progress in terms of developing strategies to deal with anxiety. Counsellor noted that he thought the miracle question was successful.	Counsellor made detailed notes before/after sessions and also during. He noted that he liked to use the notes for structure – "a burst of structure", then sit back for a few moments. The research supervisor noted that the counsellor liked to have structure available (e.g. genogram, solution focused strategies) and sometimes didn't seem comfortable with process – sitting with client without a clear direction.	-Anxiety 1/1/2 (PS/RS/CO) "Was there anything about this client's experience that you found difficult to work with?" In session 4 she said she felt we had not made any progress in developing strategies for dealing with her anxiety. I felt stumped for a while (reported at tend of all sessions).

Client Stimulus/Triggers	Counsellor Verbalizations/Response	Session Notes	Supervision	Ratings*
	talked.			
COUNSELLOR 2: SESSION 5 **EPISODE 1** Counsellor and client were discussing the clients health and various medication she uses. They then switched to reviewing the exercise the counsellor asked the client to try (miracle question). The client was unable to complete the exercise because she was not feeling well. The counsellor pulled out his notes as he asked the client to describe family further. Client tone is sad and worried. (Physical health, medication)	Under-involvement: CO: Okay. So I was wondering about the dynamics in your original family. Actually, this should be interesting. We've got here your immediate family (shows client diagram) CL: Um-hum. CO: Now, what can you tell me about the personalities of your siblings and your parents?	The counsellor reported feeling awkward during this session "even though he prepared as much as he could". The counsellor felt uncertain about the amount of progress they were making.	Counsellor made detailed notes before, during, and after sessions. He liked to use notes for structure. The research supervisor noted that he liked to have structure available (e.g. genogram, solution-focused strategies) and sometimes didn't seem comfortable with process – sitting with client without clear direction. Counsellor related that he feels like he should know more about medications. Feels it is a trap he is trying to stay out of.	-Physical Health 3/2 (PS/CO) -Medication 2 (RS) -Sad 1 (PS/RS/CO) -Worried (Scared) 1/2 (PS/CO)
EPISODE 2 The counsellor continues to take notes about the client's family background and experiences. The client discusses her abuse from her older brother John in more detail. Client's tone is angry.	Under-involvement CL: I was terrified. I was afraid to say no. I used to scream inside myself but I couldn't get the scream out. I was just terrified and I hated it and I felt dirty and I felt like I had no confidence because I felt other people could see that I was dirty.	The counsellor reported feeling awkward during this session. "even though he prepared as much as he could". He related that he felt emotional a few times when the client talked about her brother and his friend sexually abusing her. He	Counsellor related that issue of sexual abuse in Session 5 was a challenge for him. He felt awkward and not sure how the discussion would go. He was not sure what to "do with it" . (direct reference) Challenge for the counsellor to	-Siblings 2/1 (RS/CO) -Sexual Abuse 3/2/2 (PS/RS/CO) -Mad 3/2/3 (PS/RS/CO)

Client Stimulus/Triggers	Counsellor Verbalizations/Response	Session Notes	Supervision	Ratings*
(Sibling, sexual abuse)	CO: Yeah. You said earlier you felt that it showed . CL: Umhum. I thought people could see it. CO: Yes. That was your thought. CL: I thought people could see it. CO: Yeah.	was surprised that the client expressed anger instead of sadness. He did not know how to work with sexual abuse other than reflect back on what the client reported. (direct reference)	deal with anger in his own life.	
EPISODE 3 The counsellor and client continues to discuss family dynamics. The counsellor noted the client was rubbing her arms and he asked her if she was cold. She said her joints were sore due to the arthritis and an operation that put in a plastic bone. The counsellor then returned to discussing family dynamics. (Family, physical health)	Under and over involvement CL: And then I was supposed to go in and have the same thing done here but I'm afraid to go in. Bones are eroding. CO: You can see them in x-rays, I suppose. CL: Oh yeah. It's in the x-rays. CO: All right. Well, I've notices you rubbing. I don't remember you mentioning it. CL: Yeah. CO: So how do you feel about how you were in your family and as – (returns to notes)	The counsellor reported feeling awkward during this session "even though he prepared as much as he could". The counsellor felt uncertain about the amount of progress they were making.	Counsellor made detailed notes before, during, and after sessions. He liked to use notes for structure. The research supervisor noted that he liked to have structure available (e.g. genogram, solution-focused strategies) and sometimes didn't seem comfortable with process – sitting with client without clear direction.	-Parents 1/2/1 (PS/RS/CO) -Siblings 2/1 (PS/CO) -Physical Health 3/2 (PS/CO)

Client Stimulus/Triggers	Counsellor Verbalizations/Response	Session Notes	Supervision	Ratings*
COUNSELLOR 2: SESSION 6 **EPISODE 1** Extended interchange between the counsellor and client. The client began session discussing how her doctor had to take her off meds because of a damaged muscle in her heart. The counsellor is writing down notes and names of the medications and is having difficulty with spelling. The client is disappointed because she will not be able to go on a short holiday because of her health problems. The client described how everything has become cluttered at home and she feels overwhelmed. The client's tone is scared and sad. (Physical health, medication, personal stress)	Over and under –Involvement CO: And I just made some notes this morning and realizing that we just have this and two more sessions so--- CL: And I was gonna say, I'm supposed to contact the health unit to have an occupational therapist come and assess me for a scooter. CO: Oh, okay. CL: But, I'm afraid to call because they come to your home to assess and I'm – my place is just a garbage dump right now, totally cluttered. I'm embarrassed to have them come. CO: What would be the first thing – I mean, in terms of solutions, looking for solutions here, what would be the first thing you think at the top of your list, I mean these medical things that are going on we can certainly talk about them but we can't really change these.	Counsellor reported that the client had difficulty with her heart and she had to change medication. The counsellor reported that he had prepared questions for this sessions before hand. He stated that he was hoping for some "positive breakthroughs" during the sessions.	Counsellor made detailed notes before, during, and after sessions. He liked to use notes for structure. The research supervisor noted that he liked to have structure available (e.g. genogram, solution-focused strategies) and sometimes didn't seem comfortable with process – sitting with client without clear direction. Counsellor related that he feels like he should know more about medications. Feels it is a trap he is trying to stay out of.	-Physical Health 3/2 (PS/CO) -Medication 2 (RS) -Personal Stress 1/2 (PS/CO) -Sad 1 (PS/RS/CO) -Scared 1/2 (PS/CO)
EPISODE 2 The counsellor had been encouraging the client to think of ideas to help her address the clutter in her home. She felt she	Over/under-involvement: CO: So let's talk about this just for a sec. So if you had somebody come in, my thought is you could hire a student	The counsellor noted they discussed the clutter in the client's home. The counsellor felt the exploration about hiring a student to help "went	Counsellor made detailed notes before, during, and after sessions. He liked to use notes for structure. The research supervisor noted	-Personal Stress 1/2 (PS/CO) -Anxiety 1/1/2

Client Stimulus/Triggers	Counsellor Verbalizations/Response	Session Notes	Supervision	Ratings*
would like to have some one help her but she couldn't afford it. Client's tone was non-committal, neutral. (Personal stress)	to help you. CL: Um-hum. CO: And we're looking for ideas. CL: Yeah, sure. Sure. (Counsellor continues to promote idea)	well" (the judges rated this section over/under-involved). The counsellor stated that he was hoping for some "positive breakthroughs" during the sessions. He asked client how she would recognize other strategies to deal with anxiety.	that he liked to have structure available (e.g. genogram, solution-focused strategies) and sometimes didn't seem comfortable with process – sitting with client without clear direction. Continuation of surprise in Session 4 when client said she felt they hadn't developed any strategies to deal with anxiety. Counsellor kept asking "how would you recognize strategies".	(PS/RS/CO)
EPISODE 3 The client was discussing how her older sister, who lives in the apartment above her, never asks her how she is doing in terms of her health and will never follow through when the client asks her for help. The client related that she asked her sister to help her sort out her apartment, but she is always "busy". The client related that she did not want her sister's help anymore. Client's tone is irritated. (Sibling, physical health,	Over-involvement: CO: Why – I guess what I'm trying to – okay I guess what I'm trying to say is – I don't think she's the right person. CL: No, she's not. She drives me crazy so I don't want her to – CO: So this is – so you're doing great, so the idea of thinking of somebody else, this is what you want to come and help you.	The counsellor reported that he felt he and the client understood each other well (e.g. saw eye to eye) regarding her sister (the judges rated this section over–involved) Counsellor stated that he was hoping for some "positive breakthroughs" during the session.	Counsellor made detailed notes before, during, and after sessions. He liked to use notes for structure. The research supervisor noted that he liked to have structure available (e.g. genogram, solution-focused strategies) and sometimes didn't seem comfortable with process – sitting with client without clear direction. Counsellor kept asking "how would you recognize strategies). Challenge for the counsellor to deal with	-Siblings 2/1 (RS/CO) -Physical Health 3/2 (PS/CO) -Personal Stress 1/2 (PS/CO) -Mad 3/2/2 (PS/RS/CO)

Client Stimulus/Triggers	Counsellor Verbalizations/Response	Session Notes	Supervision	Ratings*
personal stress, mad)			anger in his own life.	
EPISODE 4 The client is lamenting how she finds it difficult to let go of things and people. The counsellor was trying to get her to think about any exceptions to the rule but the client found it difficult. They discussed her ex-partner. (Self-esteem, ex-partner, personal stress)	Over-involvement CO: Okay. So it's not only belongings, it's also people like your sister. CL: Oh well, I can't – CO: Is that what you meant or – CL: I meant like Steve CO: Okay. CL: Or people who weren't good for me. CO: Well, there's letting go and there's letting go. On the one hand you have let go because he is no longer in your life, okay. CL: He's dead. CO: Steve is dead? CL: I had to let go, didn't I? (laughs)	Counsellor stated that he was hoping for "some positive breakthrough" during the session.	Counsellor made detailed notes before, during, and after sessions. He liked to use notes for structure. The research supervisor noted that he liked to have structure available (e.g. genogram, solution-focused strategies) and sometimes didn't seem comfortable with process – sitting with client without clear direction. Counsellor kept asking "how would you recognize strategies".	-Self-esteem 1/1/2 (PS/RS/CO) -Personal Stress 1/2 (PS/CO) -Ex-partner 3/3 (PS/CO)
Episode 5 The client was discussing how she would like to move out of her apartment to get away	Over-involvement: CL: So, I mean, it's all her and her sons, and I love her son dearly.	The counsellor reported that he felt he and the client understood each other well (e.g. saw eye to eye) regarding	Counsellor made detailed notes before, during, and after sessions. He liked to use notes for structure. The	-Siblings 2/1 (RS/CO) -Mad

Client Stimulus/Triggers	Counsellor Verbalizations/Response	Session Notes	Supervision	Ratings*
from her sister who lives upstairs. She related how she gets so angry because her sister is so self-absorbed. Client's tone is irritated. Sibling, personal stress)	CO: I think this has been useful – I think this – I feel this - I feel this would be useful, sort of a bit of a recap and see what – CL: Yeah. CO: In terms of developing strategies this has been useful, at the end of this session. CL; Yeah, sure.	her sister (the judges rated this section over–involved) Counsellor stated that he was hoping for some "positive breakthroughs" during the session. The counsellor noted that she expressed anger in terms of this relationship and he asked "how would she deal with it" (e.g. what strategies would she use).	research supervisor noted that he liked to have structure available (e.g. genogram, solution-focused strategies) and sometimes didn't seem comfortable with process – sitting with client without clear direction. Counsellor kept asking "how would you recognize strategies". Challenge for the counsellor to deal with anger in his own life.	3/2/2 (PS/RS/CO) -Personal Stress 1/2 (PS/CO)

* Rating scale ranged from 0 (not at all difficult), 1 (slightly difficult), 2 (somewhat difficult), 3 (quite difficult) to 4 (extremely difficult)
PS= Previous Supervision; RS = Research Supervisor; CO = Counsellor

Thematic Analysis: Identifying Common Triggers

The 13 episodes for Counsellor One and the 20 episodes for Counsellor Two were analyzed further to identify common themes or triggers associated with counsellors' countertransference manifestations. The list of items used by the counsellors and supervisors to rate problematic client issues, interpersonal styles, and emotions (see Appendix E), was employed by the author to reduce the content of the client stimulus to one or two word descriptors (e.g., physical health, suicide, sexual abuse). This process allowed common triggers to be identified among the episodes. Each episode could have as many descriptors as necessary to explicate the content of the client stimulus. For example, three content themes were identified for session 3 – episode 1 for Counsellor Two: Physical Health, Self-Esteem, and Progress in Therapy – Anxiety. The number of times a theme or trigger was identified in an episode ranged from one to ten. Table 8 contains the list of the triggers that emerged for Counsellor One and Two, along with the corresponding session and episode from which the trigger was identified.

Findings of The Q Study

The findings of the Q Study supported the contention that counsellor over and under-involvement were valid indicators of countertransference manifestations. Every counsellor response that was rated as either over-involved or under-involved by the judges was preceded by client stimulus (e.g., potential triggers) that were deemed challenging for the counsellors based on multiple sources of data. Although all the triggers in Table 8 received "indirect confirmation" from the multiple sources of data, the potential triggers that received "direct confirmation" by the counsellors as problematic were most convincing because they could be clearly linked to events in the client stimulus. Thus, these findings provided preliminary support for a temporal link between countertransference behavioural manifestations and countertransference triggers.

Common themes or triggers emerged for both counsellors. These themes were as follows: physical health, mental health, family of origin, emotional arousal, and death. For Counsellor One, the triggers that emerged most frequently were physical health, emotional arousal, and helplessness. For Counsellor Two, the triggers that emerged most frequently were physical and mental health, family of origin, and emotional arousal (particularly anger).

As will be addressed further in the next chapter, these themes were consistent with the literature describing client issues that counsellors find challenging.

Table 8

Potential Triggers Identified in Client Stimulus

Counsellor One	Session	Episode(s)
Physical Health	3	1*, 2
	4	1
	5	1*, 2
	6	1, 2
Mental Health - Depression	3	2, 3*
	7	1*
Mental Health – Suicide	3	3*
Relationships – Family of Origin	3	3*
	4	2
	5	2
Loss of Control	3	1*
	4	1
	5	1*
Helplessness	3	1*, 2, 4
	4	2
Emotional Arousal – Anger	3	2, 3*
	5	1*
	6	1, 2
Emotional Arousal – Sad	3	1*, 2, 4
	4	2
	6	1
	7	1*
Emotional Arousal – Crying	3	1*, 2, 4
	4	2
	6	1
	7	1*
Emotional Arousal - Powerful	3	4
	4	3
	5	3
Perfectionism	4	1
Death	5	3
	6	1*

Counsellor Two	Session	Episode(s)
Physical Health	3	1, 4, 5
	4	2*
	5	1, 3
	6	1
Mental Health: self-esteem	3	1, 3, 4, 5
	4	2*, 3*
	6	4
Mental Health: personal stress	4	2*, 3*
	6	1, 2
Relationships - family of origin	3	1, 2, 3, 5, 6*, 7*, 8
	5	3
	6	3, 5
Relationships – boyfriend	3	2
	4	2*, 3*
	5	4
Emotional Arousal – anger	3	3, 5, 6*, 7*, 8
	4	3*
	5	2*
	6	3, 5
Emotional Arousal – sad	3	7*, 8
	4	1*
	6	1
Sexual Abuse	3	3, 6*, 7*
	5	2
Medication	4	1*
	5	1
	6	1
Death	3	5, 7*
Progress in Therapy – anxiety	3	1, 4
	4	1*

* Triggers that received direct confirmation for each counsellor.

Chapter V

Discussion

Over the last century, theorists, writers, and researchers on countertransference have struggled, debated, and even lamented over how to define and study such a complex, elusive construct. Most psychodynamic writers and therapists do not question the influence of countertransference on the therapeutic process; however, researchers attempting to study the phenomena have been stymied on how to operationalize the construct in a meaningful, measurable manner. Singer and Luborsky (1977) stated:

> How does one systematically study the core unconscious conflicts of the therapist and the extent to which they are aroused and influence his behaviour in psychotherapy? Taken to an extreme, it would almost have to require an investigator lying hidden under the couch of the patient and the analyst (under the analyst's couch during his own treatment) in order to attempt to analyze the phenomenon in systematic detail. (Singer & Luborsky, 1977, p. 49)

Although much has been written in the clinical literature about countertransference, the paucity of empirical research is notable. In particular, empirical research in naturalistic settings operationalizing countertransference in a reliable and valid manner has been lacking. Given the daunting task of trying to "systematically study the core unconscious conflicts of therapists," it is understandable that empirical research has lagged behind in this area. In spite of limited research, the impact of the counsellor's countertransference reactions on the therapeutic process has been widely acknowledged beyond the psychoanalytic community (e.g., Gelso & Hayes, 1998).

Overview of Study

The primary goal of this research was to determine whether countertransference manifestations, operationalized as over-involvement and under-involvement, could be identified within therapy sessions in a reliable and valid manner. This study focused on behavioural manifestations of countertransference because they were potentially observable and they have been identified as the more problematic aspect of countertransference in the therapeutic relationship. A multiple case study design was employed to intensely analyze the counsellors' behaviour in a naturalistic setting.

A generalizability (G) study was first conducted to assess the dependability of the

behavioural measure of countertransference and to design the decision (D) study (e.g., how many dyads, sessions, judges would be necessary to achieve a dependable measure of over/under-involvement). The G study also served to train the judges on rating the construct under investigation. The D study implemented the design specifications from the G study to address the issue of reliability (e.g., first research question). Judges' agreement constituted a reliable rating of over and under-involvement. The issue of validity was more complex, reflecting the fact that countertransference has been a challenging construct to operationalize. The conceptualization of countertransference behavioural manifestations as over-involvement and under-involvement was derived from the theoretical and empirical literature (e.g., Friedman & Gelso, 2000; Hayes et al., 1998; Wilson & Lindy, 1994). Previous research focused solely on therapists' avoidance behaviours (e.g., Rosenberger & Hayes, 1997) and overlooked negative aspects of therapists' seemingly facilitative behaviours, such as over-supporting or colluding with clients. While this broadened definition was thought to have both clinical and empirical value, over-involvement and under-involvement still only captured part of this complex construct. The Q study investigated whether there was further evidence to support operationalizing countertransference in this manner (e.g., second research question).

The Q study gathered evidence that over-involvement and under-involvement were valid indicators of countertransference behaviour by triangulating multiple data sources to identify potential countertransference triggers in the dialogue preceding the behaviour (e.g., content of client dialogue, counsellor session notes, supervision notes, counsellor and supervisors' ratings). Whereas previous research (e.g., Rosenberger & Hayes, 1998) had attempted to assess countertransference origins first (e.g., unresolved intrapsychic conflicts), then to identify countertransference triggers based on the origins, and then to predict countertransference manifestations, this study adopted Hayes et al.'s (1998) suggestion to "work backwards" by first identifying countertransference manifestations, then trying to uncover countertransference triggers and origins.

My logic was that, if potential triggers were found to precede countertransference behaviour, additional support for the construct could be established. In other words, if the supervisors and/or the therapist identified certain issues as "difficult" for the therapist -- and the analysis of the therapy sessions indicated that, when the therapist responded in an over-

involved or under-involved manner those same issues were addressed by the client -- then this finding may offer preliminary support that the behavioural observations of countertransference manifestations are, in fact, countertransference.

Key Findings: D Study

The D study found support for the first research question. Behavioural manifestations of countertransference, operationalized as over-involvement and under-involvement, were able to be identified by independent judges. Before the second research question could be addressed, it was essential to first establish a reliable measure of countertransference manifestations. The results of the G study found that a dependable measure of countertransference behavioural manifestations could be achieved through designing a study that included having three trained judges rate two counsellor-client dyads across eight therapy sessions. The generalizability coefficient for this combination of judges, dyads, and session was .79. The decision (D) study assessed interrater reliability using the intraclass correlation. The intraclass correlations for the three judges rating the counsellors' behaviour in the D study ranged from .54 to .84 for counsellor one, and .63 to .84 for counsellor two. The reliability coefficient for all eight sessions was .76 and .79 for Counsellor One and Two, respectively, lending credibility to the utility of the G study.

Several factors could have contributed to the low reliability coefficients for the first two sessions of the D study. For example, the training provided to the judges, particularly the third judge, during the G study and prior to commencing to D study could have been insufficient. It is also possible that judges required a few sessions to become familiar with a counsellor's range of response. Interestingly, the judges' agreement dropped again in session eight for both counsellors. Given that the judges rated sessions five through eight without discussing their ratings with one another, it is possible that consensus was more difficult to maintain without frequent re-calibration. The judges may have been more likely to rate the counsellors' behaviour based on their own subjective responses to the counsellors rather than stringently applying the coding scheme.

Overall, the findings suggested that countertransference manifestations could be reliably identified by independent judges. The reliability coefficients were within the range of those found in other studies employing similar rating procedures (e.g., Hayes & Gelso, 1993; and Rosenberger & Hayes, 2002). In order to focus the Q study on those samples of

counsellor behaviour that represented over-involvement and under-involvement most reliably, only those sessions with a correlation coefficient above .75 were selected for further analysis in the Q study.

For both counsellors, sessions three, four, five, six, and seven were above the cutoff. Significant over and under-involvement episodes in sessions three through seven were identified using a graphing procedure that plotted the counsellors' moving average. This procedure allowed statistically defined deviations from counsellors' "typical" responses to be identified. These deviations represented a reliably indexed movement away from an empathic stance into either over or under-involvement.

Key Findings: Q Study

The Q study found support for the second research question. Evidence that over-involvement and under-involvement were valid indicators of behavioural manifestations of countertransference was gained through establishing a temporal link between potential countertransference triggers during the session and subsequent countertransference behaviour (e.g., counsellor over or under-involvement.) Multiple sources of data were employed to identify triggers (e.g., content analysis of over/under-involvement episodes, session notes, supervision notes, and counsellor and supervisors' ratings).

There appeared to be direct and indirect support for countertransference triggers leading up to counsellor over-involvement and under-involvement. The strongest support for the validity of countertransference triggers were the triggers that received direct support from the various sources of data. Direct confirmation for a therapy event or trigger was determined if the content of the client dialogue (e.g., client stimulus) was directly referred to as problematic by the counsellor in either the session notes, the supervision sessions, or the final ratings by the counsellors and supervisors.

Potential countertransference triggers that received indirect support were also worth exploring because they were similar to those that received direct support. Indirect confirmation for a trigger was determined if the content of the client stimulus was identified by the counsellor or supervisors as a difficult issue for the counsellor "in general", but the specific event in the client stimulus was not directly referred to by the counsellor. Although the meaning of the indirect triggers was less clear than the direct triggers, both types were identified in the client stimulus preceding the counsellors' countertransference behaviour. It

is possible that the triggers receiving direct support were within the counsellors' conscious awareness, whereas the triggers receiving general support may have been outside of their awareness and may be examples of the counsellor's "blind spots." In addition, both Counsellor One and Two identified moments in the sessions that they described as "going well," whereas the judges rated their behaviour as either over-involved or under-involved and the other data sources provided some evidence that the material was challenging for the counsellor. This discrepancy in perception by the judges and the counsellors regarding "helpful" moments during sessions may also have been examples of counsellors' "blind spot." As Luborsky and Spence (1971) noted, third parties (e.g. the judges) may be more attune to detecting countertransference reactions than the counsellor.

For Counsellor One, the themes or potential triggers that emerged from the various data sources were as follows: physical health, mental health (depression and suicide), relationships-family of origin, loss of control, helplessness, perfectionism, death, and emotional arousal in the client. The themes that emerged for Counsellor Two included the following: physical health, relationships-family of origin, relationships-ex-partner, mental health (self-esteem, personal stress, anxiety, and sexual abuse), medication, death, progress in therapy-anxiety, and emotional arousal in the client.

Study Links to the Literature

Recent theory and research has conceptualized countertransference behaviour as therapists' behaviour that deviates from their baseline or general tendencies (e.g., Holmqvist, 2001; Kiesler, 2001). The current study selected episodes of counsellor over-involvement and under-involvement applying this principle. The moving averages graphing technique graphed therapists' response patterns for each session reflecting his or her departures from an empathic stance. A cutoff point was determined for each counsellor using one standard deviation above his or her mean. Thus, for each counsellor, deviations above the cutoff point were detected and were proposed as examples of over-involved or under-involved behaviour. The findings of this research provide preliminary support for conceptualizing countertransference behaviour in this manner. Although the method applied in Holmqvist's (2002) study did not allow him to identify reasons for the deviating responses, the current study was able to link deviations in counsellors' responses (e.g., over-involvement and under-involvement) to countertransference triggers.

Many of the triggers identified by the author for both counsellors in the current study received support from the literature. Hayes et al. (1998) identified various categories of countertransference origins, triggers, and manifestations. Countertransference origins were defined as areas of unresolved intrapsychic conflict for the therapist that may serve as "blind spots" for the therapist and which can impact the therapeutic relationship if they are triggered. They cited examples of origins as including family issues, therapist's needs and values such as need to help or need for control, therapy issues such as termination, and cultural issues. Countertransference triggers included therapy events that evoked the therapist's unresolved issues. Examples of triggers included the content of the client's material (e.g., death, family of origin, parenting, partner issues), changes in the therapy structure, therapist's perception of the client (e.g., as dependent or hostile), and the emotions (e.g., client expressing negative emotion). Countertransference manifestations included therapists' behaviours, thoughts, or feelings that were a consequence of unresolved issues being triggered for the therapist. Examples of manifestations included "approach" responses by the therapist (e.g., nurturing, identification, positive feelings towards the client), "avoidance" responses by the therapist (e.g., distancing self from the client, boredom or fatigue, disappointment with the client), and negative feelings by the therapist.

Many of the instances in which the counsellors' responses were rated as over or under-involvement were preceded by the client discussing issues pertaining to their illness. For example, the themes of physical health, helplessness and lack of control emerged for Counsellor One and those of physical health and medication emerged for Counsellor Two. The clinical and research literature on health care providers working with clients with serious health concerns has clearly documented the stress that these care-givers experience (e.g., Martin & Julian, 1987; Weisman, 1981). "A descriptive interview study revealed that among the more common psychological indications of caregiver stress are depression, grief and guilt, anger, irritability, frustration, over-investment and over-involvement, anxiety and difficulty with decision making helplessness and insecurity (Vachon, cited in Farber, 1994, p. 715).

Similarly, the theme "death" emerged as a trigger for both counsellors. Dunkel and Hatfield (1986) stated, "working with a person who is dying challenges unresolved feelings of one's own mortality" (p.115). Although neither of the clients were facing imminent death,

the topic of death arose in the context of the clients' personal experiences (e.g., death dream for Client One and boyfriend's attempted killing and physical deterioration for Client Two), and in the context of significant others' experiences (e.g., mother and aunt's attempted suicide for Client One and brother's accidental death for Client Two). It may have been that the counsellors' helplessness in the face of physical deterioration and/or death was sufficiently anxiety provoking that it aroused countertransferential behaviour in both these counsellors. As Counsellor One noted, the client's feelings of helplessness triggered her own feelings of helplessness and desire to "fix it." Counsellor Two seemed to focus on strategies to assess progress in therapy pertaining to anxiety and was disheartened by the client's "lack of progress."

Another trigger that emerged for both counsellors was clients' emotional arousal. Both counsellors appeared to have difficulty sitting with their clients when strong emotions such as sadness or anger were being expressed. Singer and Luborsky (1977) noted that "therapists who have less anxiety and less conflict about their own feelings are not as personally affected by the patient's expression of emotions and are able to deal with their patients more therapeutically, allowing the patient to continue to explore his threatening feelings." (p. 440). Interestingly, Counsellor One's previous supervisor and Counsellor Two's previous and research supervisor rated "anxiety management" lowest on the Countertransference Factor's Inventory (CFI-R; Latts & Gelso, 1996). This subscale contains items such as, "is comfortable in the presence of strong feelings from others"; "is comfortable with him/herself"; and "tends not to be trouble by anxiety." It is possible that anxiety management was an area of personal vulnerability for both counsellors that was more easily activated in the presence of strong emotions by others.

As Hayes et al (1998) noted, it is not only the client's emotional arousal that serves as a trigger for countertransference behavioural manifestations, but also the counsellor's emotional arousal. For example, Counsellor One reported difficulty processing a dream with her client because she had also woken up that morning from an intense dream. Counsellor Two experienced difficulty working with the client's issue of sexual abuse. He reported feeling very sad to the point that he wanted to weep and wanting revenge on the brother who abused the client. He also felt out of his element regarding working with the issue of "sexual abuse." Also, Counsellor Two was noticeably thrown off balance by the client's negative

response to his question regarding progress in dealing with anxiety in the sessions. He reported his surprise in his session notes, his supervision session, and his final ratings. These examples seem to support that counsellor's emotional arousal may also be a factor contributing to countertransference behaviour.

The findings from this study provided support for the broader, "totalistic perspective" which defines countertransference as all the therapist's reactions to his or her client, both conscious and unconscious (e.g., Kernberg, 1965). For example, those episodes during the session in which the counsellor reacted as either over-involved or under-involved, and subsequently reported problematic events (e.g., direct triggers) within the session provided support for the "conscious" reactions. The unconscious reactions were less clear. Although countertransference manifestations were identified by independent judges (e.g., not dependent on the counsellors' level of awareness to detect reactions), support for countertransference triggers came from the counsellor's self-evaluation from session notes and supervision (e.g., events within the counsellors' awareness). It may be fair to say that, because the counsellors evaluated their behaviour after the session(s), they may have become aware of their countertransferential reactions "after the fact" but not while they were engaging in countertransference behaviour. This idea is supported by the abundance of clinical literature on the topic (e.g. Singer & Luborsky, 1977).

It was impossible to ascertain whether the countertransference behaviour and triggers originated from unresolved intrapsychic conflicts in the counsellor (e.g., subjective countertransference) or whether their reactions were due to client characteristics (e.g., objective countertransference). For example, Counsellor One acknowledged certain identifications with the client regarding "mother" issues and perfectionism. Similarly, Counsellor Two identified difficulties dealing with anger in his life and difficulties working with health concerns. It may be possible that these triggers originated from unresolved intrapsychic conflicts for the counsellors; however, this study was unable to explore this possibility in sufficient depth to warrant such a conclusion.

Methodological Contributions of the Study

The methodology employed to investigate countertransference manifestations was a major contribution of this research. This current study was able to move beyond the theoretical conceptualizations, anecdotal reports, and analogue research designs that

characterize the literature on countertransference, to observe countertransference manifestations as they emerged within actual counselling sessions. The multiple case study research design allowed for intense analysis of the moment to moment interactions between the counsellors and the clients in a naturalistic setting.

In order to have confidence in research results, one requires confidence in how the concepts have been operationalized (e.g., construct validity); as well as confidence in the methods used to study the phenomenon. This study focused on countertransference behaviour because it was potentially observable by trained judges. Building on recent conceptualizations of countertransference (e.g., Friedman & Gelso, 2000; Wilson & Lindy, 1994), the construct was operationalized as counsellor over-involvement and under-involvement. As noted earlier, previous research focused on the counsellor's avoidance behaviour, hence over-looking negative aspects of counsellors' seemingly "positive" behaviour (e.g., colluding, over-supporting). The broader conceptualization allowed for a wider range of therapist behaviours to be investigated.

Another methodological contribution of this study was the attention paid to establishing a reliable index of countertransference. As noted earlier, a generalizability study was performed to increase the dependability of the behavioural measure. To date, no other research on countertransference has employed generalizability theory. Consequently, researchers interested in this topic may be able to apply the recommendations from this G study to their own research designs. In addition, the reliability data established in this study will serve as a basis of comparison for future researchers. Perhaps more importantly, this study also attempted to determine whether the behavioural observations were a valid index of countertransference. The Q study employed multiple sources of data to assess countertransference manifestations. Again, previous research has not incorporated multiple sources of data, such as session notes and supervision sessions, into the research design. A major finding of this research was that it was able to link countertransference behaviour to potential triggering events during the session. The methods employed in this study allowed for this temporal relationship between triggers and behaviour to be investigated, and hence, strengthened the validity of operationalizing countertransference behaviour as over-involvement and under-involvement.

Finally, the participants in this study (e.g., counsellors, clients, and supervisors) were unaware of the focus of the research until after all the data had been collected. One previous case study requested that the counsellor identify unresolved intrapsychic conflicts prior to commencing the counselling sessions and it is possible that collecting this data pre-session may have influenced the counsellor's behaviour in sessions. By setting up the current study so that the participants were unaware of the topic of interest, as unbiased a sample of countertransference behaviour as possible could be gathered. Individual debriefing sessions with the counsellors and clients were conducted after all the data was collected.

Limits of the Study

Single-case research designs have received both praise and criticism as a method of conducting counselling research (e.g., Galassi & Gersh, 1993; Heppner, Kivlighan, Wampold, 1992; Kazdin, 1981). On one hand, they are viewed as an excellent means of observing the counselling process as it unfolds; on the other hand, they are criticized for lacking generalizability and having problems with internal validity. The limitations of the current multiple-case research study will be discussed under the heading of "external" and "internal validity."

External Validity. A frequent criticism of single-case designs concerns their lack of generalizability. Galassi and Gersh (1992) note that it is commonly assumed that generalizability of research findings is more feasible in large-sample studies than in single-subject designs; however, this criticism is fallacious. In single-case designs the issue of generalizability or external validity is addressed through the replication of additional cases (Galassi & Gersh, 1992, Hilliard, 1993, Yin, 1989). In other words, single-case research is a category of within subject, or intrasubject, research in which the accumulation of data across cases is avoided and generalization of finding occurs through replication of subsequent cases (Hilliard, 1993). Hence the emphasis is on programmatic research, rather than "one shot deals." Consequently, explicit description of all aspects of the research process is crucial so that accurate replication can occur.

Barlow and Hersen (cited in Galassi & Gersh, 1993) described three types of replication: direct, systematic, and clinical. In direct replication the same procedures are replicated with several additional clients; with systematic replication the variable of interest, such as settings or disorders, is altered in following studies; and in clinical replication

treatment packages are tested with clients presenting similar behavioural-emotional problems. "Whereas direct replication addresses the reliability of findings or internal validity, systematic and clinical replications are concerned with generalizability or external validity" (Galassi & Gersh, 1993, p. 527). Although this multiple case study design allowed for the intensive study of two cases, generalizations to the population of counsellors in general is limited. As Galassi and Gersh (1993) noted, systematic and clinical replications are required to increase external validity. In this study, direct replication of findings across two cases provided initial support for external and internal validity.

The research presented in this dissertation was a multiple case study aimed at reliably measuring behavioural countertransference manifestations and investigating their validity in a naturalistic counselling setting. As a result, the development of construct validity was important to the generalizability of this study. Yin (1989) noted that the development of construct validation required the use of measures that truly captured the concepts under investigation. Because this issue of valid measurement has been challenging in the field of countertransference, the current research attempted to develop rigourous measures of behavioural manifestations based on the literature. Consistent with others conceptualizations, countertransference behaviour was operationalized as counsellor over-involvement and under-involvement (e.g., ICB; Friedman & Gelso, 2001; Wilson & Lindy, 1994). Additional support for operationalizing countertransference manifestations is this manner was established by identifying other factors (e.g., triggers) thought to be related to the phenomenon. This study applied Hayes et al.'s (1998) theory of countertransference origins, triggers, and manifestations to identify potential countertransference triggers thought to precede the behavioural manifestations. Thus, external validity was not only increased by conducting this research in a naturalistic setting, but also by grounding the study in relevant theory.

Internal Validity. Another major criticism of single-case designs includes threats to internal validity. In order to draw valid inferences from case studies one must be able to rule out alternative rival hypotheses of the results. Although single-case experimental designs (e.g., ABAB designs) permit superior control and manipulation of the treatment variable(s), such designs are often not applicable to clinical settings due to ethical and methodological concerns (Kazdin, 1981). For example, withdrawing treatment to return to baseline levels of

functioning can be extremely distressful for participants. Thus, non-experimental designs are often adopted. However, this concession does not mean that scientific rigour is sacrificed. Consequently, intensive single-case designs should be constructed to have high internal validity (e.g., Borg & Gall, 1989).

Because random assignment and control groups are not feasible, internal validity must be achieved though other design techniques. For example, making reliable observations and repeated measurements are vital components to improve internal validity in single-case designs (Borg & Gall, 1989). In the first situation, reliability can be achieved through careful training of observers, operationally defining the behaviours to be observed, periodic checks of observer reliability, and control for observer bias. In the latter instance, it is important to standardize the measurement procedure to minimize the contamination of treatment effects with measurement effects.

In terms of internal validity, the current study was primary concerned with establishing a reliable measure of countertransference behaviour. The following steps were taken to ensure reliable observations: one, conducting a generalizability study; two, training judges; three, operationally defining countertransference behaviour as over-involvement and under-involvement; four checking interrater reliability; and five, obtaining independent ratings to minimize rater bias.

The current study systematically collected a great deal of data from multiple sources (counsellor, supervisors, judges) across time. As Heppner et al. (1992) stated, "...the objective and subjective data collected from various perspectives allowed for comparisons to be made, and subsequently, for conclusions to be developed based on the convergence of a wide range of information rather than a single data point." (p. 172).
In other words, by reducing threats to internal validity, this research design allows greater confidence in the research findings.

A threat to internal validity arises from operationalizing countertransference as counsellor over-involvement and under-involvement because it reduces the construct to behavioural criteria that are potentially observable, but loses some of the richness of the phenomena. As Hayes and Gelso (1991) pointed out:

> An inherent difficulty in any piece of research that deals with countertransference lies in operationalizing the term. In this and previous studies, countertransference was

> operationalized usefully as the therapist's withdrawal of personal involvement in responding to a client. However, this definition of countertransference does not capture all possible manifestations of the construct nor does it share complete agreement with alternative empirical definitions of countertransference. (p. 290)

Although the authors applied a different definition than that used in the current study (e.g., withdrawal of involvement versus over and under-involvement), the sentiment still applies.

It could be argued that countertransference manifestations may best be studied by asking the counsellors to identify their own reactions as they emerge, rather than inferring their reactions from judges' observations. Although counsellors were asked to write, "what went well" and "what was challenging" after each session, and to rate what client issues they were reactive too at the end of the study, they were not directly asked to reflect on their countertransferential reactions. Because there is an abundance of anecdotal research describing therapists' self-reported reactions during sessions, the current study focused on "observed counsellor behaviour" in order to obtain as unbiased sample of countertransference behaviour as possible and to expand methods used to study countertransference. It is acknowledged that by studying counsellor's behaviour, some of the complexity and nuances of the construct are potentially over-looked.

Future Research

A strength of this research was that it moved beyond analogue research designs to employ actual counselling sessions. In addition, this research incorporated supervision sessions in the research design to include a valuable source of information regarding countertransference manifestations. It is recommended that future research continue to employ intensive case study research, including the supervision component, to establish a solid base of knowledge on this topic before developing experimental designs. As Hayes et al. (1998) noted, "it appears that researchers have jumped the gun somewhat in hypothesizing about and examining factors believed to relate to countertransference without having those hypotheses informed by empirical data from actual therapy" (p. 469).

Developing creative ways to access therapist's unresolved unconscious conflicts continues to be a challenge for future research. It is possible that this challenge is unsolvable. The current methodology focused on countertransference behavioural manifestations and

potential triggers, but did not fully explore countertransference origins. An attempt was made to incorporate ratings by others (e.g., previous supervisor and research supervisor) regarding the counsellor's reactivity to various client issues. Because the research supervisor only had contact with the counsellors on two occasions, her insight into their unresolved unconscious conflicts was necessarily limited, but still useful. Rosenberger and Hayes (1998) included ratings by the counsellor's therapist and partner, people who have longer-term contact with the counsellor and may have deeper insight into his or her blind spots. It is recommended that future research conduct in-depth interviews with the counsellor and "significant others" after all the therapy sessions are completed with the explicit purpose of identifying countertransference origins. By conducting the interviews at the end of the study, the data is protected from bias.

Although this study did not focus on the effects of countertransference behaviour on counselling outcome, the Brief Symptom Inventory (BSI; Derogatis, 1993) indicated that both clients' pre and post-measure did not change, suggesting they did not improve by the end of therapy. Interestingly, client one's BSI score dropped at the mid-point measure, whereas client two's score increased. It is difficult to ascertain the degree to which countertransference behaviour impacted treatment outcome in the current study because there is no baseline to compare whether the amount of countertransference manifested in the sessions was significant. Future research may be able to develop indices of high, medium, and low countertransference using the current methodology to explore the impact of countertransference manifestations on treatment outcome.

This research focused on identifying a reliable and valid method of measuring counsellor's countertransference behavioural manifestations. In particular, this study explored whether potential countertransference triggers could be identified in the client's behaviour/dialogue leading to the counsellor's subsequent over-involved or under-involved behaviour. Thus, no attempt was made to track the counsellor's over-involved or under-involved behaviour on the client's subsequent responses. For example, some research suggests that when clients act submissive, counsellors act dominant and vice versa (e.g., Singer & Luborsky, 1977). It would be useful for future research to track the reciprocal influence of the counsellor-client interaction. In addition, it would be interesting to include client ratings of counsellor's countertransference behaviour as another datum source. For

example, the clients could have been asked to identify moments during the session that they felt misunderstood by, distant from, or annoyed with the counsellor.

Other exciting and challenging methods to study countertransference include incorporating measures to capture physiological changes in therapist during the session. Some research has monitored therapist's autonomic responses during sessions with interesting results (e.g., Redington & Reidbord, 1992; Reidbord & Redington, 1993). Conducting this kind of research requires sensitive, sometimes costly equipment, making it out of reach for many researchers.

Implications For Practice and Training

Although countertransference has been discussed extensively in psychoanalytic journals, the construct has implications for therapists regardless of their theoretical orientation. The introduction of an intervention at a particular moment during the therapeutic process may, at times, be influenced by the therapist's reactions to the client during the session. For example, the timing of an analytical interpretation or the introduction of a behavioural strategy can both be influenced by the therapist's countertransferential reactions to the client. Helping both experienced counsellors and counsellors-in-training pay attention to their reactions to their clients is a vital ingredient in counsellor development and supervision. Consequently, the methodology and results of this study have direct implications for counsellor training and practice. Operationalizing countertransference as counsellor over-involvement and under-involvement provides a framework for which supervision could be conducted. Counsellors, along with their supervisors, could review their therapy session videotapes to identify and explore moments of over-involvement and under-involvement. Because over and under-involvement include primarily behavioural descriptors, the phenomena are more likely to be detected compared with other dimensions of countertransference. This process could be a valuable springboard to increase counsellor self-awareness regarding unresolved intrapsychic conflicts, as well as toidentify client issues that are particularly challenging for that counsellor that may require further training and continuing education.

Summary

The primary purpose of this research was to determine, one, whether independent judges could rate countertransference manifestations, operationalized as counsellor over-

involvement and under-involvement during actual counselling sessions, and two, whether there was evidence to support the contention that over and under-involvement are valid indicators of countertransference manifestations. A multiple case research design employing methodology to maximize measurement of countertransference manifestations in a reliable and valid manner was used. The results of the D study and Q study indicated preliminary support for the research questions. Inter-rater reliability was sufficiently high to support the dependability of the judges' ratings. In other words, the judges were able to reliably rate the counsellors' behaviour for empathic breaks into over or under-involvement. In addition, potential triggers leading up to counsellor over-involvement or under-involvement were identified for both counsellors in this study. These results provide preliminary support linking countertransference triggers and subsequent behavioural manifestations. Although these findings require replication, operationalizing countertransference behavioural manifestations as over-involvement and under-involvement received validation.

Footnotes

[1]Although the G study determined that only two counsellor-client dyads were required for the D study, an additional dyad was included as a back up in the event that one of the counsellors or clients withdrew their consent to participate in the study. All three dyads completed the eight sessions. One counsellor employed a counselling technique (EMDR) in several sessions that did not require much direct dialogue or interaction between the counsellor and the therapist. A decision was made to hold this dyad in reserve as a back up. Because it was not needed as a back up, this case was not analyzed.

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Appendix A

Generalizability Study

G Study

The purpose of the G study was to improve the dependability of the behavioural measurement of countertransference manifestations, conceptualized as counsellor over-involvement and under-involvement, and reduce the amount of measurement error by using data from the G study to design the decision study (D study). The G study helped to answer the question, "How many counsellor-client dyads, counselling sessions, and judges would be necessary to increase the reliability of the measure of countertransference, reduce measurement error and, consequently increase the level of generalizability?" This task was accomplished by computing variance components for each parameter of interest in the study (i.e., judge, sessions, therapists, interactions, error).

Table 1 presents the estimated variance components from the analysis of the two therapists using "therapists' countertransference behaviour" as the dependent variable. This table includes the percentage of total variance attributed by each variable (i.e., therapist dyad, rater, and session.) The variance component for therapists is the universe-score variance; it shows the amount of systematic variability between therapists in their behaviour. The estimated variance component is substantial ($\sigma^2p = .194$; 14% of total variance). This percentage indicates that therapists differed in their behaviour. The lack of variance for judges suggests that raters were in agreement with their ratings of the counsellors' behaviour. With nested designs it is impossible to separate the session main effect from the interaction between therapists and sessions. However, the negligible variance component for sessions:therapists suggests that neither session produced more behaviour than the other, nor did the relative standing of the therapists differ from one session to the other.

The interaction between judges and sessions, and the three-way interaction between therapists, judges, and sessions, and unmeasured variation are confounded in this design. The large residual component (σ^2 js,tjs,e = 1.186; 84% of the total variance) suggests that the majority of variation is due to these confounded sources (Shavelson & Webb, 1991). As noted above, the purpose of conducting a G study is to identify sources

of unwanted variation so that they can be reduced when designing a D study. "These variance components are the 'stuff' out of which particular measures are constructed for substantive research or decision-making studies." (Shavelson & Webb, 1991, p.83).

Table 1 Two Facet, Partially Nested Random G Study of Counsellor Behaviour with (s:c) x j Design

Source of Variation	df	Mean Squares	Variance Component	Estimated Variance Component	Percentage of Total Variance
Therapists(t)	1	.04532	σ^2 t	.194	14
Judges(j)	1	121.938	σ^2 j	.00003	0
Sessions:Therapists(s:t)	2	9.413	σ^2 s,ts	.028	2
tj	1	.02582	σ^2 tj	0	0
o:tj,e	1200	1.186	σ^2 js,tjs,e	1.186	84

Table 2 Formulas for Relative and Absolute Error Variance for the Two-Facet, Partially Nested (o:p) x r Design

$$\sigma^2 \text{Rel} = \frac{\sigma^2 \text{pr}}{\text{n'r}} + \frac{\sigma^2 \text{o,po}}{\text{n'o}} + \frac{\sigma^2 \text{ro,pro,e}}{\text{n'r n'o}}$$

$$\sigma^2 \text{Abs} = \frac{\sigma^2 \text{r}}{\text{n'r}} + \frac{\sigma^2 \text{pr}}{\text{n'r}} + \frac{\sigma^2 \text{o,po}}{\text{n'o}} + \frac{\sigma^2 \text{ro,pro,e}}{\text{n'r n'o}}$$

To confirm that you consent to participate in this study and that you have received a copy of this consent form for your own records, please sign the space provided below.

_____ _____

Participant's Signature Date

Sincerely,

Elsie De Vita, M.A. Dr. Beth Haverkamp

Appendix B

Counselling Process Training Manual

Counselling Process Training Manual

This manual provides standardized guidelines for judges rating counsellor and client interactions collected as part of a doctoral research project on the counselling process.

Constructs to be Rated

As a judge, you will be watching video-tapes and reading corresponding transcripts of actual counselling sessions. Using the seven-point Likert scale below, you will rate the counsellor's behaviour according to three dimensions: 1) counsellor **over-involvement; 2) counsellor empathic connection; and 3) counsellor under-involvement. These behaviours** all pertain to how the counsellor behaves towards the client. The lists of items on the pages two to four provides descriptors of the three dimensions to be rated. Please feel free to ask questions or make comments regarding the dimensions.

-3	-2	-1	0	+1	+2	+3
Underinvolved	Somewhat Underinvolved	Possibly Underinvolved Minimal Empathy	Empathically Connected	Possibly Overinvolved Minimal Empathy	Somewhat Overinvolved	Overinvolved

You will be provided with examples of these three dimensions from a video-taped counselling session to practice rating. After watching each video segment, rate each therapist response according to the three dimensions using the seven-point Likert scale. Pay attention to the intensity of the therapist's behaviour when making your ratings. If your ratings are in accordance with the other judge, rate the training tape from start to finish. As you watch the video, it is easier to first write your ratings on the corresponding transcript next to the therapist's response. Stop the video at five minute intervals (approximately two pages of transcript) to compare your ratings with the other judge. Discrepancies in ratings of two points or more should be discussed with an attempt to clarify and refine ratings.

Once training is completed, proceed to rate the four counselling sessions, two with counsellor A and two with counsellor B. Rating sheets will be provided to record your ratings.

---

1) Counsellor Under-involvement can be characterized in a variety of ways:

The counsellor....

-treated client in a punitive manner*

-was critical of the client*

-spent time complaining*

-provided too much structure*

-inappropriately questioned the client's motives*

-inappropriately took on advising tone*

-distanced him/herself from the client*

-was apathetic toward the client*

-behaved as if she or he were 'somewhere else'*

-behaved as if she or he were absent*

-rejected the client*

-redirected client away from emotion and to cognition

-body language was "under-attending," seemed avoidant or disinterested (e.g., counsellor looked away often, was constantly fidgeting, or shifting his/her body).

-voice tone was "under-attending" (e.g., counsellor's voice tone reflected irritation, boredom, withdrawal).

---

2) Counsellor Empathic Involvement can be characterized in a variety of ways:**

The counsellor....

-used facilitating skills such as reflection, summaries, clarification, labelling, and empathy

to demonstrate an understanding of the client's experience and willingness to explore issues further.

-was warm and caring

-appeared genuine in his/her interactions with the client.

-shifted the discussion from neutral issues to deeper or "less comfortable" topics.

-body language demonstrated respectful attending behaviour and suggested an openness and willingness to "be" with the client (e.g., counsellor maintained appropriate eye-contact, body posture was comfortable and non-distracting).

-voice tone was appropriate and audible (e.g, coun(e.g, cocounsellor'or's v voice was pleasant and variable, he/she sounded interested and engaged with the client).

---

3) Counsellor **Overinvolvement** can be characterized in a variety of ways:

The counsellor.....

-seemed to agree too often with the client*

-oversupported the client*

-befriended the client*

-frequently changed the topic*

-talked too much*

-acted in a submissive way*

-inappropriately apologized to the client*

-engaged in too much self-disclosure*

-colluded with the client*

-acted in a dependent manner*

-body language was "too much" or was over-attending (e.g., counsellor leaned forward too much, touched the client too soon, etc.).

-voice tone his/her voice was "too much" or was over-attending (e.g., counsellor was over-exuberant or sounded overly sympathetic).

---

*Over-involvement and Under-involvement items taken from ICB (Friedman & Gelso, 2000).

**Empathy items are taken from Bandura et al.(1960), Rosenberger and Hayes (1998), and Carl Rogers.

Please review each video-tape and corresponding transcript. You are asked to rate whether the counsellor's behaviour demonstrates empathic involvement with the client, which includes a wide range of appropriate counsellor behaviour, or whether the counsellor's behaviour demonstrates departures from an empathic stance into areas of under-involvement and/or over-involvement. The dimensions of under-involvement and over-involvement vary in intensity. For example, under-involved behaviour may range from boredom to physically leaving the session. Over-involved behaviour may range from being sympathetic to taking responsibility for the client. Rate the counsellor's behaviour in each talking turn using the 7-point Likert scale below. Please review the definitions of the constructs provided in the manual as a reminder.

Record your ratings on the rating sheet provided. As you watch the video, it is easier to first write your ratings on the corresponding transcript next to the counsellor's response. After watching five minutes of the session, approximately two pages of the transcript, stop the video to transfer your ratings to the rating sheet. You can review your ratings at this time and rewind the video if you wish to reconsider ratings. Please feel free to stop the video at any time to review parts of the session.

Rate the counsellor's behaviour in each talking-turn using the scale below.

-3	-2	-1	0	+1	+2	+3
Underinvolved	Somewhat Underinvolved	Possibly Underinvolved Minimal Empathy	Empathically Connected	Possibly Overinvolved Minimal Empathy	Somewhat Overinvolved	Overinvolved

1 ____	21 ____	41 ____	61 ____	81 ____	101 ____	121 ____	141 ____	161 ____
2 ____	22 ____	42 ____	62 ____	82 ____	102 ____	122 ____	142 ____	162 ____
3 ____	23 ____	43 ____	63 ____	83 ____	103 ____	123 ____	143 ____	163 ____
4 ____	24 ____	44 ____	64 ____	84 ____	104 ____	124 ____	144 ____	164 ____
5 ____	25 ____	45 ____	65 ____	85 ____	105 ____	125 ____	145 ____	165 ____
6 ____	26 ____	46 ____	66 ____	86 ____	106 ____	126 ____	146 ____	166 ____
7 ____	27 ____	47 ____	67 ____	87 ____	107 ____	127 ____	147 ____	167 ____
8 ____	28 ____	48 ____	68 ____	88 ____	108 ____	128 ____	148 ____	168 ____
9 ____	29 ____	49____	69 ____	89 ____	109 ____	129 ____	149 ____	169 ____
10 ____	30 ____	50 ____	70 ____	90 ____	110 ____	130 ____	150 ____	170 ____
11 ____	31 ____	51 ____	71 ____	91 ____	111 ____	131 ____	151 ____	171 ____
12 ____	32 ____	52 ____	72 ____	92 ____	112 ____	132 ____	152 ____	172 ____
13 ____	33 ____	53 ____	73 ____	93 ____	113 ____	133 ____	153 ____	173 ____
14 ____	34 ____	54 ____	74 ____	94 ____	114 ____	134 ____	154 ____	174 ____
15 ____	35 ____	55 ____	75 ____	95 ____	115 ____	135 ____	155 ____	175 ____
16 ____	36 ____	56 ____	76 ____	96 ____	116 ____	136 ____	156 ____	176 ____
17 ____	37 ____	57 ____	77 ____	97 ____	117 ____	137 ____	157 ____	177 ____
18 ____	38 ____	58 ____	78 ____	98 ____	118 ____	138 ____	158 ____	178 ____
19 ____	39 ____	59 ____	79 ____	99 ____	119 ____	139 ____	159 ____	179 ____
20 ____	40 ____	60 ____	80 ____	100____	120 ____	140 ____	160 ____	180 ____

Appendix C

Introductory Letters and Informed Consent Documents
Letters of Agreement for Affiliate Professionals and Judges

Appendix D

Demographic Questionnaires

Client Background Information Sheet

The following questions request some background information. The top half of the form contains standard information requested of clients when entering counselling. This information will be viewed solely by the researcher and your counsellor. The bottom half of the form contains demographic information that will be used for descriptive purposes in the study. Please take a few moments to complete the questions.

Name: _____

Address: _____

Phone: _____

Emergency Contact: _____
(Name & Number)

Can a message be left at home? Yes ____ No ____

---

1. Age: _____ 2. Sex: M ____ F ____

3. Highest level of education: _____

4. Ethnic Background: _____

5. Marital Status: _____

6. Do you have children? Yes ____ No _____ If Yes, how many: _____

7. In a few sentences, describe your main concerns, including your health concerns:

_____
_____
_____
_____
_____
_____
_____

Counsellor Background Information Sheet

The following questions request some background information. The top half of the form requests your phone number and will be used solely by the researcher. The bottom half of the form contains demographic information that will be used for descriptive purposes in the study. Please take a few moments to complete the questions.

Name: _____

Phone: _____

Can a message be left at home? Yes ____ No ____

---

1. Age: _____ 2. Sex: M ____ F ____

3. Highest level of education: _____

4. Specialization: _____

5. Ethnic Background: _____

6. Marital Status: _____

7. Do you have children? Yes ____ No _____ If Yes, how many: _____

8. Years and months counselling experience: _____

9. What is your theoretical orientation is counselling?

_____

_____

_____

10. What types of client issues/populations do you have the most experience with?

_____

_____

_____

Appendix E

Countertransference Triggers
Rating Sheets for Counsellors and Supervisors

Counsellor Questionnaire
To Be Completed After All Sessions Are Finished

Please respond to the following questions based not only on your experience with this client, but also on your experience in general with clients. For example, based on your personal experiences and life history, you may find that you are more sensitive to certain issues but not to others. Please be as candid as possible.

Based on your self-assessment, please use the five point Likert scale to rate your level of difficulty dealing with, or reactivity to, the following client issues, presentation styles, and emotions.

0	1	2	3	4
Not at All Difficult	Slightly Difficult	Somewhat Difficult	Quite Difficult	Extremely Difficult

A. Relationships	
1. Parents	
2. Siblings	
3. Partner	
4. Ex-partner	
5. Children	
6. Step-children	
7. Friends	
8. Extra-marital	
9. Co-workers	
10. Therapists	
11. Other	
B. Mental Health	
12. Depression	
13. Anxiety	
14. Suicidal A/B	
15. Sexual Abuse	
16. Substance Misuse	
17. Sexuality	
18. Self-esteem	
19. Chronic Pain	
20. Anger Management	
21. Personal Stress	
22. Other	

C. Physical Health	
23. Cancer	
24. HIV/AIDS	
25. Diabetes	
26. Heart Disease	
27. Minor Complications	
28. Weight Issues	
29. Other	
D. Devel. Period	
30. Infancy	
31. Childhood	
32. Adolescence	
33. Adulthood	
34. Present	
E. Misc.	
35. Education	
36. Divorce	
37. Death	
38. Other	
Client Presentation	
39. Assured/Dominant	
40. Gregarious/Extravert	
41. Warm/Agreeable	
42. Unassuming/Ingenu.	
43. Unassured/Submis.	
44. Aloof/Introverted	
45. Cold-Hearted	
46. Arrogant/Calculating	
Client Emotions	
47. Mad	
48. Sad	
49. Scared	
50. Joyful	
51. Powerful	
52. Peaceful	
53. Other	

Counsellor Questions
To Be Completed After All Sessions Are Finished

Are there any issues you are less effective working with that have not been accounted for in the questionnaire?

Was there anything about this client's experience that you found difficult to work with?

How were you different with this client compared to how you usually are?

Supervisor Questionnaire

Based on your knowledge of the counsellor participating in this research study, please use the five point Likert scale to rate the counsellor's level of difficulty dealing with, or reactivity to, the following client issues, presentation styles, and emotions.

0	1	2	3	4
Not at All Difficult	Slightly Difficult	Somewhat Difficult	Quite Difficult	Extremely Difficult

A. Relationships	
1. Parents	
2. Siblings	
3. Partner	
4. Ex-partner	
5. Children	
6. Step-children	
7. Friends	
8. Extra-marital	
9. Co-workers	
10. Therapists	
11. Other	
B. Mental Health	
12. Depression	
13. Anxiety	
14. Suicidal A/B	
15. Sexual Abuse	
16. Substance Misuse	
17. Sexuality	
18. Self-esteem	
19. Chronic Pain	
20. Anger Management	
21. Personal Stress	
22. Other	

C. Physical Health	
23. Cancer	
24. HIV/AIDS	
25. Diabetes	
26. Heart Disease	
27. Minor Complications	
28. Weight Issues	
29. Other	
D. Devel. Period	
30. Infancy	
31. Childhood	
32. Adolescence	
33. Adulthood	
34. Present	
E. Misc.	
35. Education	
36. Divorce	
37. Death	
38. Other	
Client Presentation	
39. Assured/Dominant	
40. Gregarious/Extravert	
41. Warm/Agreeable	
42. Unassuming/Ingenu.	
43. Unassured/Submis.	
44. Aloof/Introverted	
45. Cold-Hearted	
46. Arrogant/Calculating	
Client Emotions	
47. Mad	
48. Sad	
49. Scared	
50. Joyful	
51. Powerful	
52. Peaceful	
53. Other	

Given what you know about the counsellor's personal history and counselling skill, are there any other client issues and characteristics not already identified that he or she may be sensitive or reactive to in a counselling setting? Please explain.

Appendix F

Countertransference Factors Inventory - Revised

Form-T

The therapist:	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1. recognizes similarities between current and former clients.	1	2	3	4	5
2. has a stable sense of identity.	1	2	3	4	5
3. is often aware of personal areas of unresolved conflict.	1	2	3	4	5
4. usually restrains him/herself from excessively identifying with the client's conflicts.	1	2	3	4	5
5. accurately labels client's emotions.	1	2	3	4	5
6. is often aware of feelings in him/her elicited by clients.	1	2	3	4	5
7. understands the background factors in his/her life that have shaped his/her personality.	1	2	3	4	5
8. tends to resolve his/her own emotional conflicts.	1	2	3	4	5
9. is usually emotionally "in tune" with clients.	1	2	3	4	5
10. 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
11. effectively sorts out how his/her feelings relate to client's feelings.	1	2	3	4	5
12. often sees things from the client's point of view.	1	2	3	4	5
13. conceptualizes relationship dynamics in terms of the client's past.	1	2	3	4	5
14. is comfortable in the presence of strong feelings from others.	1	2	3	4	5

Form-T

The therapist:	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
15. possesses a "gut-level" self-understanding.	1	2	3	4	5
16. is usually able to conceptualize client dynamics or issues clearly.	1	2	3	4	5
17. intuitively understands clients.	1	2	3	4	5
18. is often aware of his/her personal impact on others.	1	2	3	4	5
19. at the appropriate times, puts aside his/her intellect and "feels" with the client.	1	2	3	4	5
20. does not experience a great deal of anxiety while conducting therapy.	1	2	3	4	5
21. effectively distinguishes between client's needs and his/her own needs.	1	2	3	4	5
22. can usually apply a theoretical orientation to cases.	1	2	3	4	5
23. is often aware of fantasies in him/her triggered by client material or affect.	1	2	3	4	5
24. usually comprehends how his/her feelings influence him/her in the therapy.	1	2	3	4	5
25. can usually identify dynamics of the counseling relationship.	1	2	3	4	5
26. recognizes the limits of his/her clinical competencies.	1	2	3	4	5
27. feels confident working with most clients.	1	2	3	4	5
28. is psychologically balanced.	1	2	3	4	5
29. has a sense of autonomy.	1	2	3	4	5
30. is usually able to assess the severity of client issues.	1	2	3	4	5

Form-T

The therapist:	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
31. conceptualizes cases deeply.	1	2	3	4	5
32. can usually identify with the client's inner experience.	1	2	3	4	5
33. will reformulate an initial diagnosis if warranted by client material.	1	2	3	4	5
34. has the capacity to stand back from his/her own emotional experience and observe what is going on with him/herself.	1	2	3	4	5
35. gets beyond the manifest content to the latent meanings of a client's verbalizations.	1	2	3	4	5
36. usually recognizes his/her own negative feelings.	1	2	3	4	5
37. is comfortable with him/herself.	1	2	3	4	5
38. is comfortable being close to others.	1	2	3	4	5
39. often uses his/her past experiences to aid in understanding the client.	1	2	3	4	5
40. is willing to consider him/herself as an impediment to client progress.	1	2	3	4	5
41. does not become overly anxious in the presence of most client problems.	1	2	3	4	5
42. reflects deeply on his/her own feelings.	1	2	3	4	5
43. effectively recognizes the boundaries between self and others.	1	2	3	4	5
44. possesses self-confidence.	1	2	3	4	5

Form-T

The therapist:	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
45. is perceptive in his/her understanding of clients.	1	2	3	4	5
46. usually manages his/her need for approval.	1	2	3	4	5
47. usually connects strands of the client's material.	1	2	3	4	5
48. effectively judges a client's readiness to explore particular issues.	1	2	3	4	5
49. tends not to be troubled by anxiety.	1	2	3	4	5
50. often conceptualizes his/her role in what transpires in the counseling relationship.	1	2	3	4	5

Appendix G

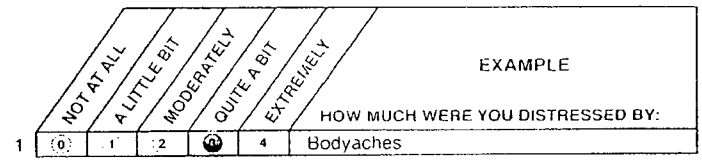
Study Announcements

Appendix H

Brief Symptom Inventory

INSTRUCTIONS:

On the next page is a list of problems people sometimes have. Please read each one carefully, and blacken the circle that best describes HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY. Blacken the circle for only one number for each problem and do not skip any items. If you change your mind, erase your first mark carefully. Read the example before beginning, and if you have any questions please ask them now.



	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY	HOW MUCH WERE YOU DISTRESSED BY:
1	0	1	2	3	4	Nervousness or shakiness inside
2	0	1	2	3	4	Faintness or dizziness
3	0	1	2	3	4	The idea that someone else can control your thoughts
4	0	1	2	3	4	Feeling others are to blame for most of your troubles
5	0	1	2	3	4	Trouble remembering things
6	0	1	2	3	4	Feeling easily annoyed or irritated
7	0	1	2	3	4	Pains in heart or chest
8	0	1	2	3	4	Feeling afraid in open spaces or on the streets
9	0	1	2	3	4	Thoughts of ending your life
10	0	1	2	3	4	Feeling that most people cannot be trusted
11	0	1	2	3	4	Poor appetite
12	0	1	2	3	4	Suddenly scared for no reason
13	0	1	2	3	4	Temper outbursts that you could not control
14	0	1	2	3	4	Feeling lonely even when you are with people
15	0	1	2	3	4	Feeling blocked in getting things done
16	0	1	2	3	4	Feeling lonely
17	0	1	2	3	4	Feeling blue
18	0	1	2	3	4	Feeling no interest in things
19	0	1	2	3	4	Feeling fearful
20	0	1	2	3	4	Your feelings being easily hurt
21	0	1	2	3	4	Feeling that people are unfriendly or dislike you
22	0	1	2	3	4	Feeling inferior to others
23	0	1	2	3	4	Nausea or upset stomach
24	0	1	2	3	4	Feeling that you are watched or talked about by others
25	0	1	2	3	4	Trouble falling asleep
26	0	1	2	3	4	Having to check and double-check what you do
27	0	1	2	3	4	Difficulty making decisions
28	0	1	2	3	4	Feeling afraid to travel on buses, subways, or trains
29	0	1	2	3	4	Trouble getting your breath
30	0	1	2	3	4	Hot or cold spells
31	0	1	2	3	4	Having to avoid certain things, places, or activities because they frighten you
32	0	1	2	3	4	Your mind going blank
33	0	1	2	3	4	Numbness or tingling in parts of your body
34	0	1	2	3	4	The idea that you should be punished for your sins
35	0	1	2	3	4	Feeling hopeless about the future
36	0	1	2	3	4	Trouble concentrating
37	0	1	2	3	4	Feeling weak in parts of your body
38	0	1	2	3	4	Feeling tense or keyed up
39	0	1	2	3	4	Thoughts of death or dying
40	0	1	2	3	4	Having urges to beat, injure, or harm someone
41	0	1	2	3	4	Having urges to break or smash things
42	0	1	2	3	4	Feeling very self-conscious with others
43	0	1	2	3	4	Feeling uneasy in crowds, such as shopping or at a movie
44	0	1	2	3	4	Never feeling close to another person
45	0	1	2	3	4	Spells of terror or panic
46	0	1	2	3	4	Getting into frequent arguments
47	0	1	2	3	4	Feeling nervous when you are left alone
48	0	1	2	3	4	Others not giving you proper credit for your achievements
49	0	1	2	3	4	Feeling so restless you couldn't sit still
50	0	1	2	3	4	Feelings of worthlessness
51	0	1	2	3	4	Feeling that people will take advantage of you if you let them
52	0	1	2	3	4	Feelings of guilt
53	0	1	2	3	4	The idea that something is wrong with your mind

Appendix I

Session Notes

Counsellor

To Be Completed After Each Session and Faxed to Dr. Scalzo. Return original to Elsie De Vita with video tape.

Session Notes: Content and Process

Use other side of page if necessary.

From your perspective, what went well during the session and what was difficult during the session? Can you recall any specific moments, exchanges, or client statements that were particularly significant to your feeling effective? To your feeling less effective?

Use other side of page if necessary.

Appendix J

Supervision Questions

Registered Psychologist

Questions To Be Asked During Supervision

During the first supervision session, please address the following general questions:

1) How do you find the sessions to date?

2) What seems to be going well during the sessions?

3) Are there any client issues that are posing a challenge for you?

During the final supervision session, please address the following general questions:

1) How did you find the sessions overall?

2) What worked well between you and the client?

3) Were there any client issues that posed a challenge for you?

Appendix K

Frequency Distributions

Frequency of Judges Rating of Over-involvement/Under-involvement Across Counsellors and Therapy Sessions

Counsellor 1: Session 1 N = 101	Rater 1	Rater 2	Rater 3
Under-Involved (-3)	--	1	--
Somewhat Under-Involved (-2)	2	3	2
Possible Under-Involvement (-1)	39	14	10
Empathic Involvement (0)	50	64	71
Possible Over-Involvement (+1)	10	15	18
Somewhat Over-Involved (+2)	--	4	--
Over-Involved (+3)	--	--	--

Counsellor 1: Session 2 N = 204	Rater 1	Rater 2	Rater 3
Under-Involved (-3)	--	1	2
Somewhat Under-Involved (-2)	8	19	7
Possible Under-Involvement (-1)	32	25	32
Empathic Involvement (0)	71	130	122
Possible Over-Involvement (+1)	85	28	39
Somewhat Over-Involved (+2)	8	1	2
Over-Involved (+3)	--	--	--

Counsellor 1: Session 3 N = 128	Rater 1	Rater 2	Rater 3
Under-Involved (-3)	--	--	1
Somewhat Under-Involved (-2)	10	12	16
Possible Under-Involvement (-1)	44	35	28
Empathic Involvement (0)	40	56	62
Possible Over-Involvement (+1)	22	12	17
Somewhat Over-Involved (+2)	12	13	4
Over-Involved (+3)	--	--	--

Counsellor 1: Session 4 N = 122	Rater 1	Rater 2	Rater 3
Under-Involved (-3)	--	--	--
Somewhat Under-Involved (-2)	4	1	4
Possible Under-Involvement (-1)	27	23	16
Empathic Involvement (0)	46	79	68
Possible Over-Involvement (+1)	35	15	29
Somewhat Over-Involved (+2)	10	4	5
Over-Involved (+3)	--	--	--

Counsellor 1: Session 5 N = 167	Rater 1	Rater 2	Rater 3
Under-Involved (-3)	--	--	--
Somewhat Under-Involved (-2)	--	5	--
Possible Under-Involvement (-1)	30	16	18
Empathic Involvement (0)	85	114	113
Possible Over-Involvement (+1)	47	25	31
Somewhat Over-Involved (+2)	5	7	5
Over-Involved (+3)	--	--	--

Counsellor 1: Session 6 N = 144	Rater 1	Rater 2	Rater 3
Under-Involved (-3)	--	--	--
Somewhat Under-Involved (-2)	--	--	--
Possible Under-Involvement (-1)	3	1	2
Empathic Involvement (0)	69	90	116
Possible Over-Involvement (+1)	61	41	24
Somewhat Over-Involved (+2)	11	11	2
Over-Involved (+3)	--	1	--

Counsellor 1: Session 7 N = 134	Rater 1	Rater 2	Rater 3
Under-Involved (-3)	--	--	--
Somewhat Under-Involved (-2)	--	1	--
Possible Under-Involvement (-1)	16	22	6
Empathic Involvement (0)	69	55	95
Possible Over-Involvement (+1)	42	46	32
Somewhat Over-Involved (+2)	7	10	1
Over-Involved (+3)	--	--	--

Counsellor 1: Session 8 N = 227	Rater 1	Rater 2	Rater 3
Under-Involved (-3)	--	--	--
Somewhat Under-Involved (-2)	--	--	--
Possible Under-Involvement (-1)	8	4	4
Empathic Involvement (0)	120	160	187
Possible Over-Involvement (+1)	98	56	31
Somewhat Over-Involved (+2)	1	7	5
Over-Involved (+3)	--	--	--

Frequency of Judges Rating of Over-involvement/Under-involvement Across Counsellors and Therapy Sessions

Counsellor 2: Session 1 N = 383	Rater 1	Rater 2	Rater 3
Under-Involved (-3)	--	--	--
Somewhat Under-Involved (-2)	8	10	10
Possible Under-Involvement (-1)	43	42	36
Empathic Involvement (0)	99	115	195
Possible Over-Involvement (+1)	190	199	129
Somewhat Over-Involved (+2)	40	15	13
Over-Involved (+3)	3	2	--

Counsellor 2: Session 2 N = 432	Rater 1	Rater 2	Rater 3
Under-Involved (-3)	--	--	1
Somewhat Under-Involved (-2)	8	15	8
Possible Under-Involvement (-1)	76	52	42
Empathic Involvement (0)	76	147	260
Possible Over-Involvement (+1)	259	202	90
Somewhat Over-Involved (+2)	13	15	31
Over-Involved (+3)	--	1	--

Counsellor 2: Session 3 N = 362	Rater 1	Rater 2	Rater 3
Under-Involved (-3)	--	9	3
Somewhat Under-Involved (-2)	45	49	40
Possible Under-Involvement (-1)	127	119	76
Empathic Involvement (0)	81	112	139
Possible Over-Involvement (+1)	99	63	95
Somewhat Over-Involved (+2)	9	8	7
Over-Involved (+3)	1	2	2

Counsellor 2: Session 4 N = 22	Rater 1	Rater 2	Rater 3
Under-Involved (-3)	--	--	--
Somewhat Under-Involved (-2)	2	6	15
Possible Under-Involvement (-1)	56	51	53
Empathic Involvement (0)	85	103	94
Possible Over-Involvement (+1)	70	47	57
Somewhat Over-Involved (+2)	16	22	9
Over-Involved (+3)	--	--	1

Counsellor 2: Session 5 N = 295	Rater 1	Rater 2	Rater 3
Under-Involved (-3)	--	--	1
Somewhat Under-Involved (-2)	12	20	16
Possible Under-Involvement (-1)	90	86	77
Empathic Involvement (0)	91	124	180
Possible Over-Involvement (+1)	92	54	15
Somewhat Over-Involved (+2)	10	11	6
Over-Involved (+3)	--	--	--

Counsellor 2: Session 6 N = 261	Rater 1	Rater 2	Rater 3
Under-Involved (-3)	2	3	--
Somewhat Under-Involved (-2)	19	27	10
Possible Under-Involvement (-1)	23	25	93
Empathic Involvement (0)	37	104	107
Possible Over-Involvement (+1)	142	66	39
Somewhat Over-Involved (+2)	37	36	11
Over-Involved (+3)	1	--	1

Counsellor 2: Session 7 N = 237	Rater 1	Rater 2	Rater 3
Under-Involved (-3)	--	--	--
Somewhat Under-Involved (-2)	4	3	3
Possible Under-Involvement (-1)	53	38	29
Empathic Involvement (0)	116	169	159
Possible Over-Involvement (+1)	56	25	40
Somewhat Over-Involved (+2)	8	2	6
Over-Involved (+3)	--	--	--

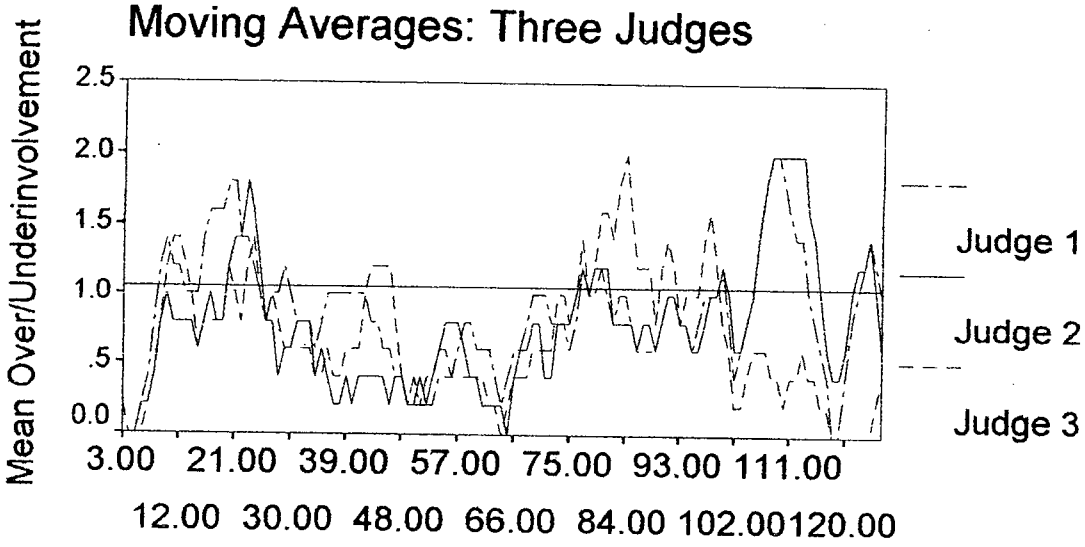
Counsellor 2: Session 8 N = 212	Rater 1	Rater 2	Rater 3
Under-Involved (-3)	--	--	--
Somewhat Under-Involved (-2)	40	37	12
Possible Under-Involvement (-1)	49	39	51
Empathic Involvement (0)	40	46	120
Possible Over-Involvement (+1)	72	79	23
Somewhat Over-Involved (+2)	10	10	5
Over-Involved (+3)	1	1	1

Appendix L

Moving Averages Graphs: Three Judges

Graph 11

Moving Averages: Three Judges

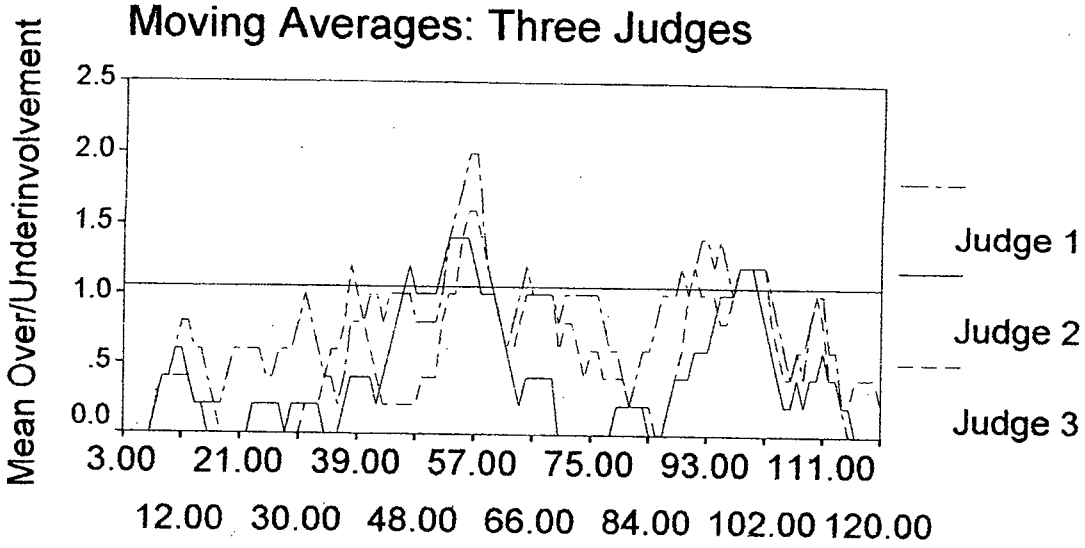


Talking Turn

Counsellor 1 Session 3

Cutoff = 1.05

Graph 12



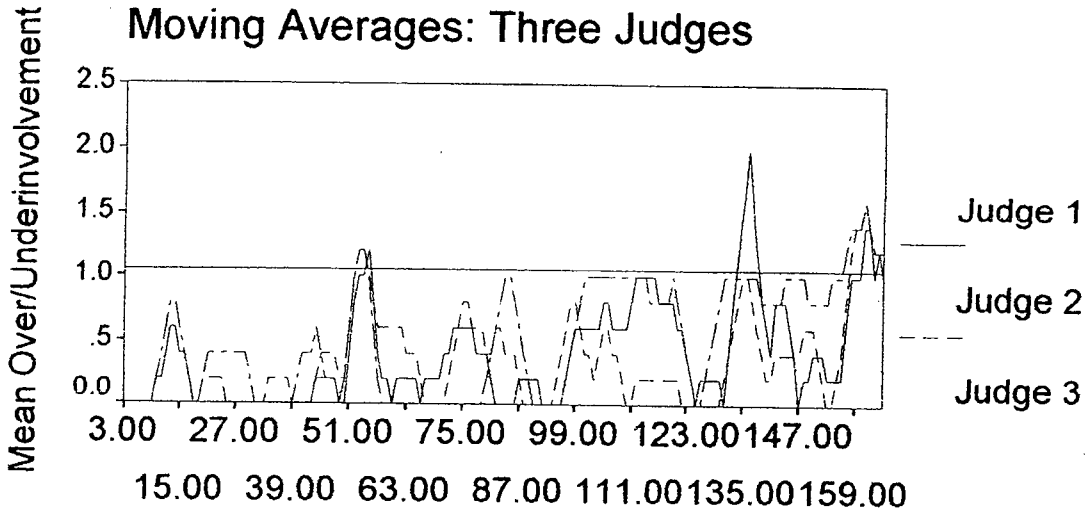
Talking Turn

Counsellor 1 Session 4

Cutoff = 1.05

Graph 13

Moving Averages: Three Judges

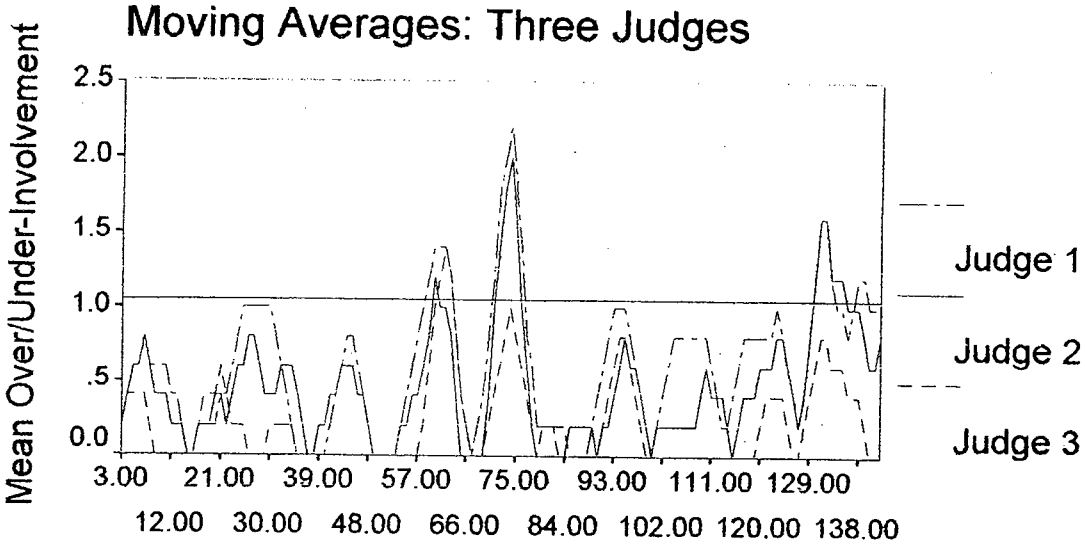


Talking Turn

Counsellor 1 Session 5

Cutoff = 1.05

Graph 14

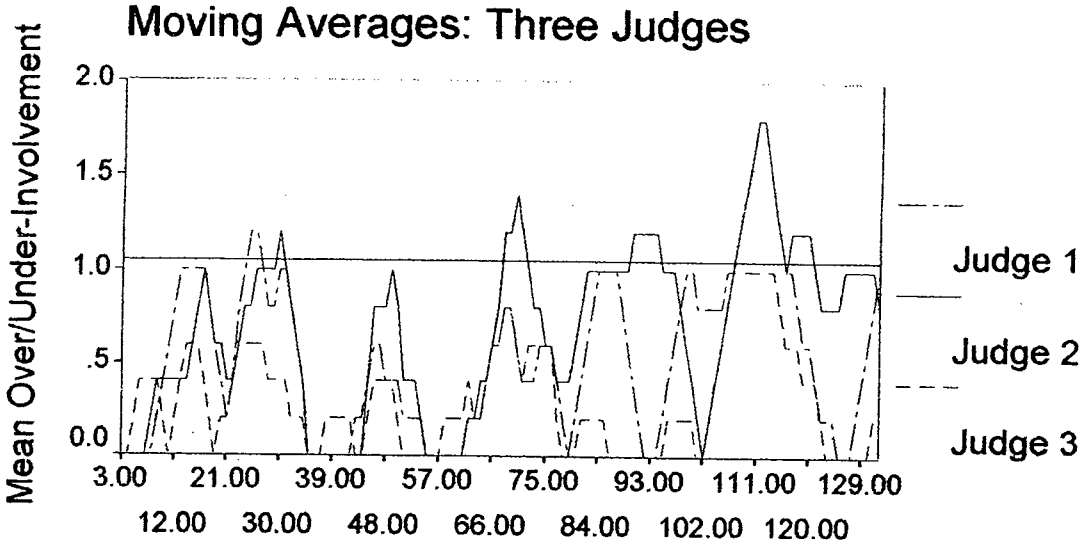


Talking Turn

Counsellor 1 Session 6

Cutoff = 1.05

Graph 15



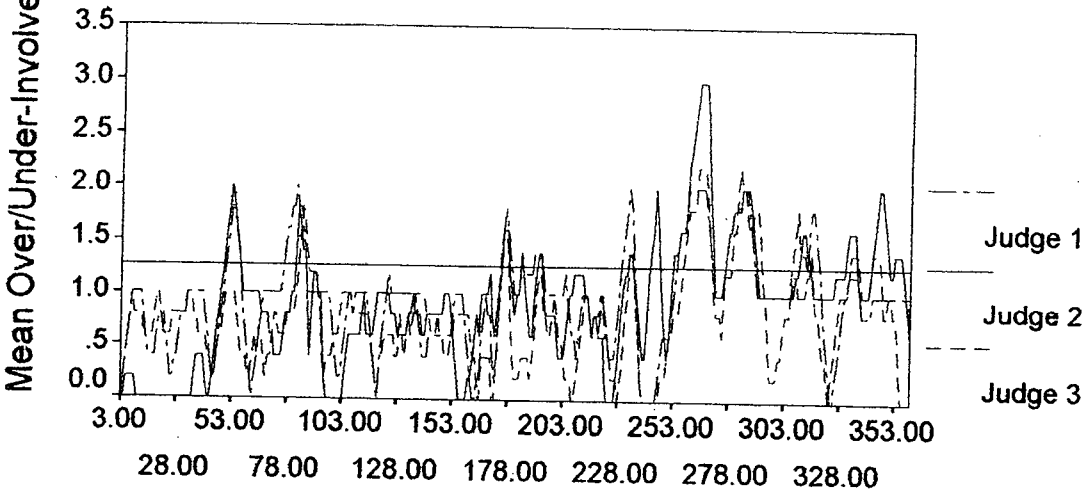
Talking Turn

Counsellor 1 Session 7

Cutoff = 1.05

Graph 16

Moving Averages: Three Judges



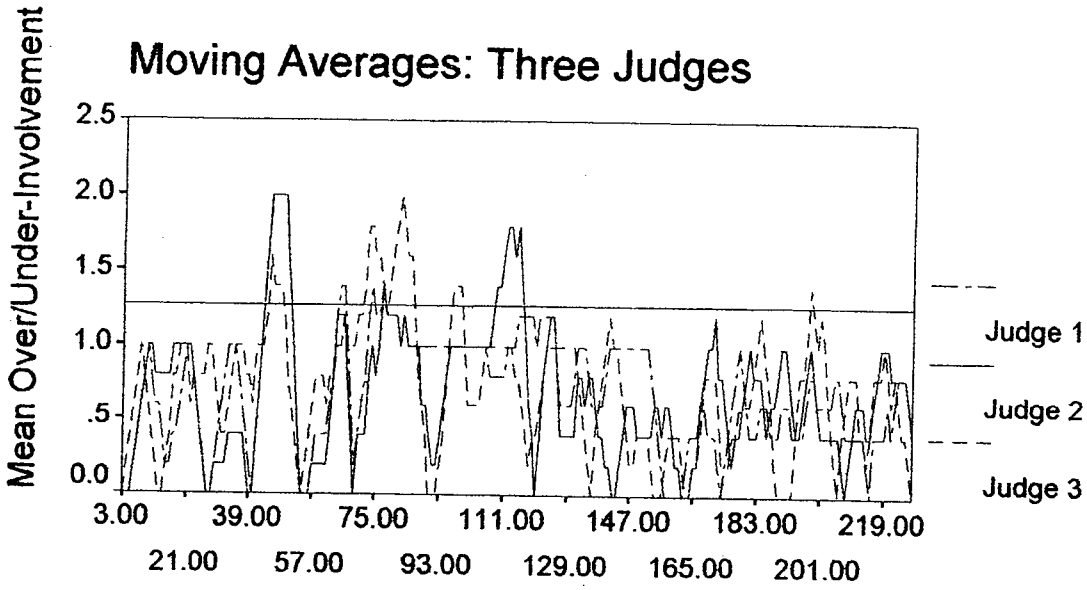
Talking Turn

Counsellor 2 Session 3

Cutoff = 1.27

Graph 17

Moving Averages: Three Judges



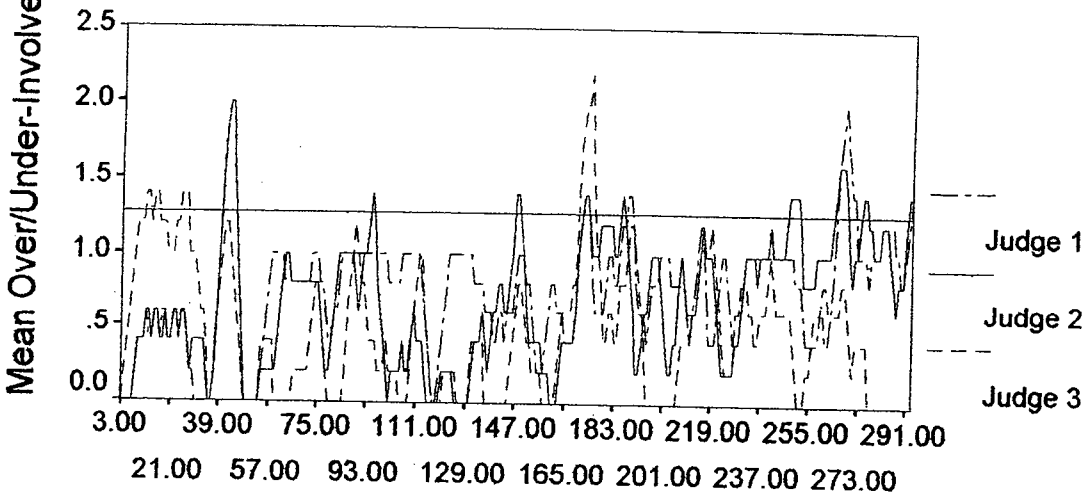
Talking Turn

Counsellor 2 Session 4

Cutoff = 1.27

Graph 18

Moving Averages: Three Judges



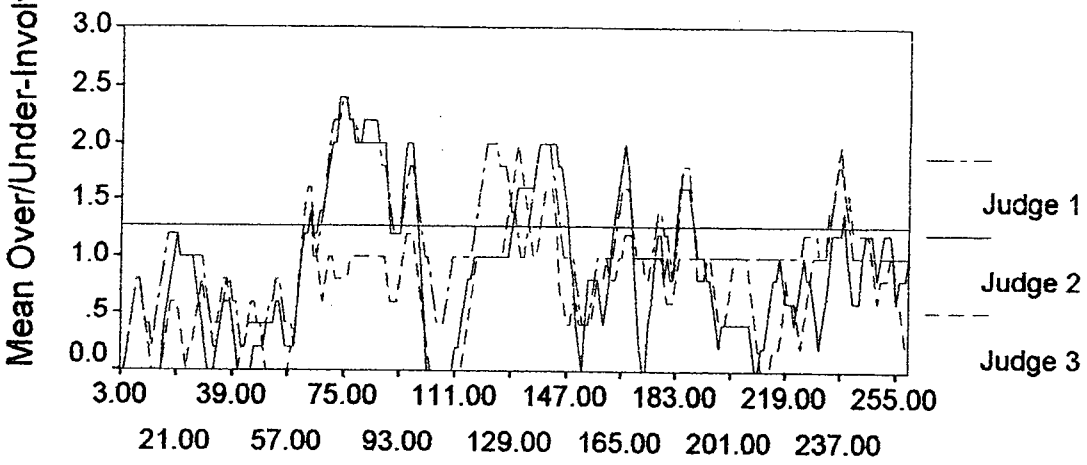
Talking Turn

Counsellor 2 Session 5

Cutoff = 1.27

Graph 19

Moving Averages: Three Judges



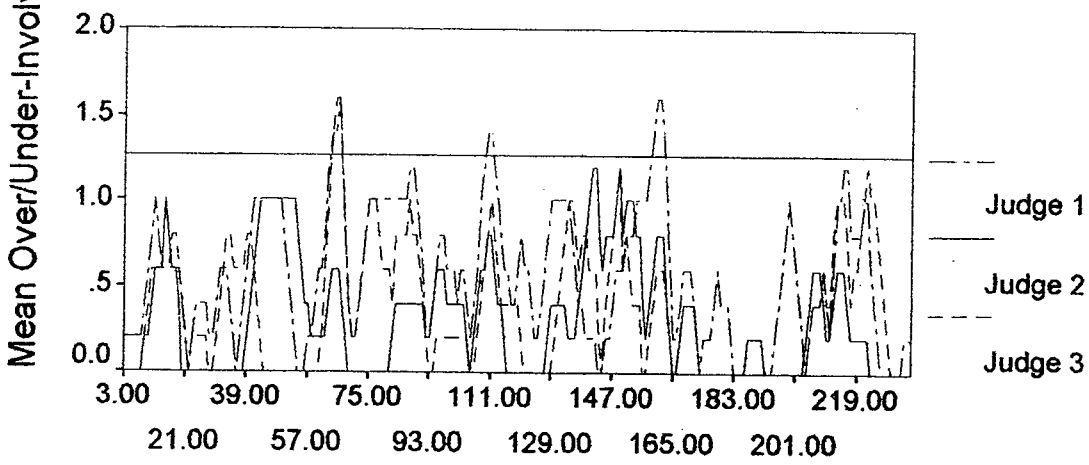
Talking Turn

Counsellor 2 Session 6

Cutoff = 1.27

Graph 20

Moving Averages: Three Judges



Talking Turn

Counsellor 2 Session 7

Cutoff = 1.27

Appendix M

Ethical Approval Certificates

Appendix N

Debriefing Information

Client and Counsellor Debriefing Information

As outlined in the original consent form, this study is exploring the counsellor-client interaction across brief-term counselling. The focus of the study is on the counsellor's behaviour. All counselling sessions can be characterized by a continuum of counsellor movement towards and away from clients. I am interested in whether this movement can be paired with session content and whether it may be characterized as counsellor over-involvement or under-involvement in some instances. Some research suggests that when counsellors are emotionally triggered during sessions, their ability to remain empathically connected to the client is challenged. It is during these moments that they may behave in an over-involved or under-involved manner towards their clients. A variety of things during sessions can trigger counsellors. For example, clients may be talking about issues that are difficult for counsellors to deal with. Sometimes the clients and/or their issues remind the counsellors of someone they know. Often clients' pain and suffering may trigger a reaction in the counsellors. These reactions can be mild or strong, or even outside our awareness. Being able to identify these moments when counsellors are "reacting" has important implications for supervision and counsellor development. It is the hope of this study to contribute to the field of research that investigates counsellor development.

To Counsellor:

Are you surprised that this was the focus of the study? Do you recall experiencing any strong reactions to your client? Would you like to discuss them?

To Client:

Are you surprised that this was the focus of the study? Do you recall sensing any strong reactions like this from your counsellor? Would you like to discuss them?