Countertransference Behavior and Management in Brief Counseling: A Field Study

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COUNTERTRANSFERENCE BEHAVIOR AND MANAGEMENT IN BRIEF COUNSELING: A FIELD STUDY

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The relationship between countertransference (CT) behavior and factors theorized to facilitate CT management was examined in a study of 20 counseling dyads. Previous supervisors' ratings of counselors' empathy and self-integration were found to relate negatively to counselors' CT behavior. Furthermore, CT behavior was inversely related to treatment impact in cases with poor to moderate treatment results but was unrelated to treatment impact in successful cases. These data suggest that CT is not successfully managed in cases with poor to moderate treatment results so that the adverse effect on treatment results is proportionate to the amount of CT exhibited. In successful counseling, however, CT may be managed in such a way that the overall amount present is unrelated to treatment results.

Clinical lore and a scant amount of research suggest that countertransference (CT) is a double-edged sword for therapists. If unchecked, it is likely to lead to countertherapeutic behavior on the part of the therapist. However, if a therapist is aware of CT, it can serve as a valuable source of insight into the psychotherapy relationship.

While there is as yet no single accepted definition of CT, most experts in the field of psychotherapy agree that CT reactions need to be recognized, attended to, and managed in order for counseling to proceed effectively (Peabody & Gelso, 1982; Robbins & Jolkovski, 1987). Recently, the management of CT has begun to receive attention from researchers seeking to ascertain the personal qualities that help a therapist to effectively manage CT reactions. In an analog study, Robbins and Jolkovski (1987) found that counselors' awareness of CT feelings was inversely related to CT behavior, especially when counselors strongly adhered to a theoretical framework. Van Wagoner, Gelso, Hayes, and Diemer (1991) hypothesized the existence of five factors thought to help counselors productively manage CT: self-insight, anxiety management, conceptual skills, empathy, and self-integration. Results from their study supported the prediction that these five factors would distinguish reputedly excellent therapists, presumed to be expert at managing CT, from average therapists.

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Correspondence regarding this article should be addressed to Jeffrey A. Hayes, Ph.D., 312 CEDAR Building, Pennsylvania State University, University Park, PA 16802-3110.
In the present study we attempted to provide further insight into the management of CT within the context of actual counseling. We believed that a field study would be valuable in complementing the analog studies that constitute the majority of research on CT (Gelso, Fassinger, Gomez, & Latts, 1995; Hayes & Gelso, 1991, 1993; Latts & Gelso, 1995; Peabody & Gelso, 1982; Robbins & Jolkovski, 1987; Yulis & Kiesler, 1968). Furthermore, we wanted to utilize supervisors' viewpoints to provide a third-person perspective in measuring CT. Because clinicians often are unaware of their CT, studying this construct "would almost have to require an investigator lying hidden under the couch of the patient" (Singer & Luborsky, 1977, p. 449), or instead, a supervisor who observed a counselor's and client's interactions.

Based on the data obtained by Van Wagoner et al. (1991), we expected to find an inverse relationship between CT behavior and the degree to which counselors possessed factors believed to facilitate CT management. Furthermore, consistent with findings from previous, mainly analog research, we hypothesized that CT behavior would relate negatively to treatment impact. This hypothesis was thought to be important because, to the best of our knowledge, the relationship between CT and treatment results has not been examined previously in a field study, except in a single-case format (Strupp, 1980a,b).

METHODS

PARTICIPANTS AND SELECTION PROCEDURES

Counseling Dyads. Counselor participants were 20 (15 women, 5 men) counseling psychology doctoral students enrolled in practicum courses at a large, research university in the Midwest. Counselors ranged in age from 22 to 46 years ($M = 30.8, SD = 7.4$). Sixteen of the counselors were European American, 1 Hispanic American, 2 Asian American, and 1 Native American. Fifteen of the counselors had completed at least one previous practicum course and all had completed a pre-practicum training course. The researchers asked counseling psychology students taking a practicum course to volunteer for a study examining counselors' reactions to clients. Counselors were informed that they would be required to complete brief inventories related to their work with a client, and that by participating in the study, they would be entered in a lottery for a $100 savings bond.

Client participants were 20 (10 women, 10 men) students seeking help at a campus psychology clinic. The 20 clients (17 European American, 3 African American) ranged in age from 19 to 46 years ($M = 25.4, SD = 7.0$). Clients' most common self-reported concerns were stress (reported by 60% of clients), romantic relationships (40%), and career issues (35%). Clients gave written consent during their intakes to participate in the study. For the 20 dyads, treatment duration ranged from 4 to 20 sessions ($M = 8.0, SD = 2.2$).

Supervisors. Two groups of supervisors participated in the study. Counselors' former supervisors were identified by counselors as persons who had supervised their clinical work within the past year but were not supervising them currently. Thirteen of the former supervisors were advanced doctoral
students in counseling psychology and five were faculty members. Eleven former supervisors were females and seven were males. Also participating in the study were counselors’ current practicum supervisors, all of whom were advanced doctoral students in counseling psychology and half of whom were females. The researchers asked them to volunteer for a study examining supervisees’ reactions to clients, informed them about what their participation would entail, and entered participants in the same lottery as counselors for a $100 savings bond.

INSTRUMENTS

Counselor factors believed to facilitate the management of CT were measured with the Countertransference Factors Inventory-Revised (CFI-R). The original Countertransference Factors Inventory (CFI) was a 50-item, 5-point Likert instrument designed “to measure the extent to which therapists possess certain interrelated qualities or characteristics theorized to be important in the management of countertransference” (Van Wagoner et al., 1991, p. 414). Those qualities were conceptual skills, self-insight, anxiety management, empathy, and self-integration. The CFI was revised by this study’s first author after an investigation of its content validity (Hayes, Gelso, Van Wagoner, & Diemer, 1991). The CFI-R contains 26 items from the original scale that had acceptable content validity as determined by 33 experts in the area of CT (Hayes et al., 1991). In particular, on a 5-point Likert scale (1 = Not Important, 5 = Very Important), these 26 items had an average mean-item score of 4.3, as opposed to an average mean-item score of 3.9 for the 50 items on the original CFI. Of the 26 items, 10 were from the original Self-integration scale (e.g., “able to recognize boundaries between self and others”), 8 from Self-insight (e.g., “aware of own feelings elicited by clients”), 4 from Anxiety Management (e.g., “not overly anxious in the presence of most client problems”), and 4 from Empathy (e.g., “able to see things from client’s point of view”). (Because only one item from the Conceptual Skills scale had acceptable content validity, it was not included in the CFI-R.) Although the CFI-R has not been used previously, the CFI demonstrated evidence of construct validity in discriminating effectively between reputedly excellent and average therapists, and internal consistency (α) estimates for its subscales range from .88 to .92 (Van Wagoner et al., 1991). In the current study, internal consistency (α) values for the subscales were .80 for Empathy, .62 for Self-insight, .80 for Anxiety Management, and .83 for Self-integration, and intercorrelations among subscales ranged between .56 and .89. In addition to the standard form of the CFI-R that was filled out by counselors’ former supervisors, a self-report version of the CFI-R was created by changing pronouns within items (e.g., from “she/he” to “I”). Counselors’ total CFI-R scores were found to be unrelated to former supervisors’ total scores (r = -.16).

Counselors’ and supervisors’ estimates of CT were measured with the Countertransference (CT) Index. Created for this study, it is a single, 5-point Likert item (1 = Strongly Disagree, 5 = Strongly Agree) indicating the extent to which “the counselor’s behavior in session was influenced by countertransference (i.e., areas of unresolved conflict).” The CT Index was designed to be completed by counselors and supervisors immediately after each counseling session, and because we thought that counselors and supervisors might change their ratings following supervision, they also completed the CT Index after each
supervision session. Results indicated that counselors' pre- and post-supervision scores were highly correlated ($r = .97, p < .01$) as were supervisors' ($r = .86, p < .01$). Consequently, pre- and post-supervision scores on the CT Index were averaged for subsequent analyses. Counselors' and supervisors' scores on the CT Index were positively correlated ($r = .62, p < .01$), providing evidence of interrater reliability for the measure.

Counselors' in-session verbal behavior also was used to measure CT. Counselors' verbal behavior was assessed according to criteria established by Bandura, Lipsher, and Miller (1960), who categorized counselors' responses in terms of approach and avoidance. Those counselor responses judged to "elicit from the patient further expressions of . . . feelings, attitudes, and behavior" (Bandura et al., 1960, p. 2) were classified as approach responses. By contrast, those responses judged to inhibit, discourage, or divert the client from further exploration or expression of a theme were classified as avoidance responses. Approach responses have been found to relate positively and avoidance responses negatively to counseling outcome with a variety of clients (Campbell & Browning, 1975; Caracena, 1965; Varble, 1968). Furthermore, recent analog research has provided evidence for the construct validity of avoidance behavior as a measure of CT (Gelso et al., 1995; Hayes & Gelso, 1993; Latts & Gelso, 1995). Although no formal training on classifying counselor verbal behavior was provided to supervisors, each supervisor met with one of the researchers to discuss the classification schema and clarify questions. Scores for avoidance behavior were calculated to reflect the proportion of counselor responses categorized by supervisors as avoidant.

Treatment impact was assessed with the Counseling Services Assessment Blank (CSAB), a 27-item instrument designed to provide an evaluation of services offered by a counseling agency (Hurst, Weigel, Thatcher, & Nyman, 1969). The CSAB contains Likert and open-ended items concerning clients' demographics, perceived gains from counseling, and satisfaction with individual counseling, group counseling, and agency facilities. In the present study, only those Likert items pertaining to perceived gain from and satisfaction with individual counseling were used, and parallel forms for counselors and supervisors were derived. The CSAB was chosen because of its suitability to a college counseling agency and because it has been judged to have adequate content validity and reliability (June, 1985). For example, Butler (1979) reported that the median test-retest reliabilities for the 10 items used in the present study were .67 after one month and between .57 and .62 after two years. Butler also presented data indicating that the test-retest reliability of the same items over a 2–6 month period ranged from .70 to .97. In the present study, internal consistency for the 10 items was .84.

**PROCEDURE**

Clients provided demographic information, a description of presenting concerns, and consent to participate in the study during their intake at a university psychology clinic. Prior to seeing clients, counselors completed the CFI-R, provided demographic information, and supplied the name of someone other than their current supervisor who had supervised their clinical work in the past year. Former supervisors were contacted by mail and asked to complete the
CFI-R with respect to their former supervisees. After several follow-ups, the CFI-R was completed by former supervisors for 17 of the 20 counselors.

All counseling sessions were observed live by supervisors via closed circuit cameras. During their live observation of every session, supervisors kept written count of the number of counselor verbalizations judged to be either avoidance responses, approach responses, or neither, using the definitions provided by Bandura et al. (1960) that were described above. Immediately after each counseling session, counselors and their current supervisors independently completed the CT Index. Supervisors and counselors met weekly for supervision, and immediately afterward, each independently completed the CT Index again.

Approximately two weeks after termination, counselors, clients, and supervisors were sent a cover letter, a prepared return envelope, and the CSAB. The two-week delay was instituted to minimize the effects of the final session on CSAB ratings. Reminder letters and new CSAB forms were sent to nonrespondents two weeks and four weeks after the initial mailing. CSAB forms were returned by 12 clients (60% response rate), 18 counselors (90%) and 20 supervisors (100%).

RESULTS

Our initial hypothesis was that CT behavior would be inversely related to the degree to which counselors possessed factors thought to facilitate CT management, namely self-insight, anxiety management, empathy, and self-integration. To test this hypothesis, Pearson correlation coefficients were calculated between both counselors' and former supervisors' CFI-R subscale scores and three measures of CT: supervisors' CT Index, counselors' CT Index, and supervisors' ratings of counselors' avoidance behavior. Results indicated that counselors' self-report scores on the CFI-R subscales were unrelated to each of the measures of CT ($-14 \leq r \leq .30, p > .05$). However, as reflected in Table 1, previous supervisors' ratings of counselor empathy and self-integration were inversely related to counselor avoidance behavior ($- .39 \leq r \leq -.40, p \leq .05$). Former

Table 1. Correlation Coefficients Between Former Supervisors' Ratings on CFI-R Subscales and Countertransference Measures

<table>
<thead>
<tr>
<th>CFI-R Subscale (Mean, SD)</th>
<th>Supervisor CT Index</th>
<th>Counselor CT Index</th>
<th>Avoidance Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-insight (3.10, 0.45)</td>
<td>.03</td>
<td>-.10</td>
<td>-.37</td>
</tr>
<tr>
<td>Anxiety Management (3.42, 0.73)</td>
<td>.18</td>
<td>.04</td>
<td>-.09</td>
</tr>
<tr>
<td>Empathy (3.79, 0.56)</td>
<td>-.06</td>
<td>-.31</td>
<td>-.39*</td>
</tr>
<tr>
<td>Self-integration (3.71, 0.51)</td>
<td>-.01</td>
<td>-.10</td>
<td>-.40*</td>
</tr>
</tbody>
</table>

*p $\leq .05$, one-tailed. Means and standard deviations for countertransference measures were as follows: Supervisor CT Index: $M = 2.80, SD = 0.85$; Counselor CT Index: $M = 2.71, SD = 0.93$; Avoidance Behavior: $M = 12.40, SD = 9.69$. 
supervisors' ratings of counselor self-insight and anxiety management were not related to any of the CT measures.

Our second hypothesis was that CT behavior would relate negatively to treatment impact. To test this hypothesis, Pearson correlation coefficients were calculated between the three measures of CT (supervisors' CT Index, counselors' CT Index, and supervisors' ratings of counselors' avoidance behavior) and four measures of treatment impact: CSAB scores from clients, counselors, and supervisors, and a composite variable that averaged the CSAB scores. As reflected in Table 2, none of the 12 correlations was statistically significant at the .05 level, although 11 were in the expected negative direction. To investigate why the relationship between CT and treatment impact was not significant, Pearson correlation coefficients between the three measures of CT and the composite CSAB score then were calculated separately for successful cases and less successful cases. Successful cases were defined a priori as having an average mean item score on the composite CSAB of 3.67 or higher, representing the upper third of the Likert scale on the CSAB. In the 12 successful cases, the three measures of CT were unrelated to treatment impact (\(-.03 \leq r \leq .14\)). In the eight less-successful cases, however, CT was strongly related to treatment impact, as revealed in Table 2 (\(-.87 \leq r \leq -.25\)).

**DISCUSSION**

The veracity of any conclusions based on the findings above rests on the assumption that the instruments employed actually measure the constructs they were intended to measure. Because this assumption seems tenuous with regard to the CT Index, and to a lesser degree, the CFI-R, we thought it might be prudent to begin our discussion by noting the questionable construct validity of these instruments.

Our initial interest was in determining how well CT behavior could be

| Table 2. *Correlation Coefficients Between Countertransference and CSAB Measures* |
|----------------------------------|----------------------------------|----------------------------------|-----------------------------------|
| CSAB Measure (Mean, SD)          | Supervisor CT Index              | Counselor CT Index               | Avoidance Behavior                |
|                                  | All Cases (N = 20)               |                                  |                                   |
| Client CSAB (4.16, 0.68)         | -.22                             | -.19                             | -.15                              |
| Counselor CSAB (3.74, 0.65)      | -.07                             | -.03                             | .25                               |
| Supervisor CSAB (3.70, 0.48)     | -.16                             | -.07                             | -.25                              |
| Composite CSAB (3.80, 0.46)      | -.20                             | -.17                             | -.03                              |
| Composite CSAB (4.09, 0.33)      | .00                              | .14                              | -.03                              |
| Composite CSAB (3.38, 0.21)      | -.87*                            | -.69**                           | -.25                              |

| Successful Cases (n = 12)        |                                  |                                  |                                   |
| Less Successful Cases (n = 8)    |                                  |                                  |                                   |

*p < .01, one-tailed. **p < .05, one-tailed.*
predicted by the extent to which counselors possessed factors theorized to relate to CT management. The negative correlations between supervisors' CFI-R ratings and counselors' avoidance behavior lend credence to the notion that counselor empathy and self-integration facilitate CT management in such a way that CT behavior is less likely to occur. The negative correlation between empathy and avoidance behavior replicated a trend in Peabody and Gelso's (1982) data toward an inverse relationship between empathy and CT behavior. It seems the more that counselors are able to be attuned to clients' feelings, the less inclined they are to act defensively in accordance with their own needs. Therapists' self-integration, or possession of a healthy, intact character structure, is believed to facilitate CT management through the recognition of ego boundaries. The ability to differentiate self from client is critical to the process of entering into the client's world while simultaneously monitoring one's own internal reactions. The counselors in our study who were less well-integrated may have been more prone to confuse the clients' needs with their own and thus display self-serving behavior such as avoiding client material.

The fact that counselors' scores on the CFI-R did not correlate with former supervisors' CFI-R scores or with measures of CT raises questions about the utility of using a self-report method to assess factors pertinent to CT management, at least for counselors-in-training. Counseling trainees may lack sufficient clinical experience and/or self-awareness to accurately report the extent to which they possess factors such as empathy and self-integration. Research is needed to determine the validity of self-reported CFI-R scores with more experienced therapists.

The data pertaining to the relationship between CT and the CSAB challenge the assumption that CT necessarily leads to poor treatment results. In fact, the nonsignificant correlations between CT and the CSAB indicate that CT was present in roughly equal amounts in successful and less-successful cases. However, the relationship between CT and the CSAB differed depending upon the quality of treatment impact. In successful cases, the amount of CT present was unrelated to the CSAB whereas in less-successful cases, higher levels of CT strongly predicted lower CSAB scores. It could be that in the successful dyads, CT was unrelated to perceived gains from and satisfaction with counseling because a strong working alliance was established that overrode the effects of CT, a possibility raised by Sifneos (1987) and requiring further investigation. The data also suggest that CT was not successfully managed in cases with low to moderate CSAB scores. Counselors' failure to manage CT might explain the negative relationship between CT and treatment impact in the less successful cases. Because CT was not managed effectively, its adverse influence on treatment was proportionate to the amount of CT counselors' experienced, a finding consistent with previous research indicating that negative interpersonal processes strongly predict poor therapy outcome (Henry, Schacht, & Strupp, 1986).

Why is CT so detrimental to counseling if it is not managed properly? Gelso and Carter (1994) theorized that for counseling to be successful, distorted components of the therapy relationship (i.e., CT and transference) must eventually dissipate enough to allow counseling participants to relate to one another in a reality-based fashion. Relationships predicated and sustained on illusory perceptions are not likely to succeed in helping clients attain their goals.

Although data from the CFI-R indicate that CT management was facilitated
by counselor characteristics such as empathy and self-integration, it is not evident what other factors may have been helpful to counselors in managing CT. For instance, we did not examine the degree to which CT was focused on in supervision nor the ways in which supervision may have been conducive to CT management. Furthermore, we did not assess the extent to which the counselors' training program addressed CT issues. Future research is needed to discover how activities such as didactic instruction, individual or peer supervision, reviewing session tapes, or receiving psychotherapy might facilitate CT management.

Several important limitations of the present study require that our findings be viewed tentatively. In addition to the questionable construct validity of the CT Index and the CFI-R, the reliability of supervisors' ratings of avoidance behavior was unknown and may impinge on the robustness of our findings. Furthermore, the small size of this sample limited our statistical power; a larger number of counseling dyads would be required to detect the apparently modest relationships that exist among the variables under investigation. Still further, the use of a single instrument to measure satisfaction with and perceived gains from counseling restricts statements about actual client improvement. Type I error represents another limitation to the study, given the relatively large number of analyses conducted. Still further, the novice nature of most of the supervisors may have influenced their sensitivity to and reporting of CT. Particularly problematic is the possibility that supervisors' ratings of avoidance behavior influenced their ratings on the CT Index. Finally, examining doctoral students engaged in brief counseling limits the generalizability of the results to other counselors and longer work. Due to the aforementioned limitations, the findings from this study should be viewed as preliminary and in need of replication. It would be especially helpful to further explore the possibility raised by our post hoc findings that CT behavior is unrelated to treatment impact in successful counseling but may be strongly predictive of treatment impact for moderately successful and unsuccessful cases.

REFERENCES


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**Zusammenfassung**


**Résumé**

La relation entre le comportement de contre-transfert (CT) et les facteurs théorésens sensés faciliter la gestion du CT a été examinée dans une étude de 20 dyades en consultations. Les évaluations antécédentes des superviseurs sur l'empathie et l'auto-intégration des thérapeutes ont montré une relation négative avec leur comportement de CT. De plus, le comportement de CT était inversement lié à l'impact du traitement dans des cas de résultats de traitement faibles à modérés, mais n'était pas lié aux impact de traitements dans de cas de succès. Les données suggèrent que le CT n'est pas géré avec succès dans les cas où les résultats de traitement sont faibles à modérés, de telle sorte que l'effet contraire sur les résultats du traitement est proportionnel à la quantité de CT manifesté. Toutefois lors de consultations réussies, le CT semble être géré de telle manière qu'il ne porte pas préjudice, quelle qu'en soit l'intensité, aux résultats du traitement.

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