The extent to which therapists who were reputed to be excellent differ from the therapists in general is examined, with respect to five qualities theorized to be important in the management of countertransference feelings—self-insight, integration, empathy, anxiety management, and conceptualizing ability. A sample of experienced psychotherapists (n = 122) evaluated therapists they selected as excellent significantly more positively than therapists in general on all five of the theorized qualities. Contrary to expectation, reputedly excellent psychodynamic, learning, and humanistic therapists were generally rated as equivalent on these theorized qualities. Reputedly excellent psychodynamic therapists, however, were rated more favorably than excellent humanistic therapists on conceptualizing ability.

The concept of countertransference has been a matter of great attention, debate, and revision since the concept was first used by Freud (Peabody & Gelso, 1982; Robbins & Jolkovski, 1987). For Freud and other classical psychoanalytic theorists, countertransference includes only those reactions to the client that are triggered by the analyst's own unconscious needs and neurotic conflicts, and are viewed as inappropriate and potentially damaging to the therapeutic endeavor (Arlow, 1985; Reich, 1951, 1960). A more contemporary definition posits countertransference as all of the therapist's feelings and attitudes toward the client (Fromm-Reichmann, 1950; Heimann, 1950; Giovacchini, 1975; Kernberg, 1975). The most pertinent criticism of this "totalist" definition is that if countertransference is to include both unconscious, conflict-based feelings toward the client, as well as reality-based feelings, it becomes overly inclusive and too broad to be useful (Gelso & Carter, 1985; Watkins, 1985). While these definitional disputes have yet to be resolved, a common element of all of the definitions is that the therapist's internal reactions need to be attended to, understood, and in one way or another, managed. An imperative for the therapist, therefore, is to bring these reactions into awareness, examine them, and use them in the service of the work, rather than permitting them to impede effective treatment (Fromm-Reichmann, 1950; Gelso & Carter, 1985; Heimann, 1950; Reich, 1960).

While there is generally a dearth of empirical work on countertransference itself, a few studies have examined ways in which therapists behave countertransferentially with their clients. Countertransference behavior in the form of therapist withdrawal, antagonism, or hostility has been shown to emerge in the presence of client material that is in an area of unresolved conflict for therapists (Cutler, 1958), client transference (Luborsky & Singer, 1974; Mueller, 1969), and intensely negative client emotion (Beery, 1970; Gamsky & Farwell, 1966; Haccoun & Lavigueur, 1979). Such behavior has been shown to contribute to unsuccessful counseling outcomes (Singer & Luborsky, 1977). While these studies demonstrate the po-
tentially negative impact the client can have on therapist behavior, not all therapists respond countertransferentially to client material, transference, or emotion. Might some therapists be especially good at managing their countertransference? Do therapists who manage countertransference well possess special qualities that help them do this, or is their ability simply a function of their general therapeutic skill?

We wondered whether a therapist who is considered excellent by colleagues would differ from the average therapist in the management of countertransference and, if so, in what ways. Does the reputedly excellent therapist possess qualities that allow him or her to moderate countertransference feelings so they do not contaminate the process? Do reputedly excellent therapists differ from therapists in general in terms of these qualities or characteristics? Additionally, do reputedly excellent male and female therapists differ on these characteristics? Finally, do reputedly excellent therapists whose orientations are primarily psychodynamic, humanistic, and behavioral in fact differ from one another, in terms of qualities that moderate countertransference?

The present study sought to answer the above questions. In order to do so, however, we first needed to develop conceptualization of the factors that we thought mediate how a therapist manages countertransference feelings. Based on a review of the theoretical and empirical literature, we theorized the existence of five interrelated factors: (a) self-insight, (b) empathic ability, (c) self-integration, (d) anxiety management, and (e) conceptualizing ability.

Therapist self-insight refers to the extent to which a therapist is aware of one’s own feelings and understands their basis. For Freud (1910/1959), the analyst’s ability to help the analysand is impeded by one’s own resistances and unconscious conflicts. The analyst must, therefore, recognize countertransference, and then begin a process of analyzing the basis for these reactions. Robbins and Jolkovski (1987) found that awareness of countertransference feelings was inversely related to withdrawal of counselor involvement with the client, a measure of countertransference behavior. They concluded that therapists who are aware of their feelings are in a better position to do something about them before they are manifested behaviorally. These findings suggest that therapist insight into countertransference feelings allows one to remain engaged effectively in the therapeutic interaction.

Empathic ability, our second ingredient, consists of both affective empathy, that is, the ability to put oneself into another’s shoes and temporarily partake of that one’s feelings; and diagnostic empathy, the intellectual understanding of the other’s experience. Empathy, in psychoanalytic theory, consists of a partial or trial identification with the client’s emotional experience, and this partial identification serves as an avenue for understanding the client’s inner world (Arlow, 1985; Greenson, 1960; Reich, 1951; 1960). Countertransference occurs, however, when the therapist is unable to extricate him or herself from this identification. A study by Peabody and Gelso (1982) provides partial empirical support for this conception. They found empathic ability to be positively related to awareness of countertransference feelings, which in turn, was inversely related to countertransference behavior. In addition, Peabody and Gelso (1982) found a trend toward a negative relationship between empathic ability and countertransference behavior. These findings suggest that empathic ability might be a moderator of countertransference in the sense that the empathic therapist is typically more aware of one’s own countertransference feelings, putting one in a better position to do something about them, before they interfere with the therapeutic endeavor.

A third factor theorized to be important to the management of countertransference, self-integration, broadly refers to the therapist’s psychological health and possession of a stable identity, and includes the ability to differentiate oneself from others, as well as the ability to put aside one’s own needs in the service of the client. Cutler (1958) found that therapists were more likely to respond in an ego-oriented, countertransferral manner to client material that was in an area of unresolved conflict for the therapist, suggesting that the more psychologically sound a therapist is, the less likely countertransference will impede the work. Therapist’s must possess the ability to partake of the client’s emotional experience, but also the capacity to stand back from this trial identification and observe it from an objective, analytic stance (Greenson, 1960; Reich, 1960). Greenson (1960) emphasizes that the critical requirement is to “partake of the quality and not the degree of the feelings, the kind, and not the quantity” (p. 418). Self-integration is closely related to this empathic process. Greenson (1960) discusses the “pathology of empathy” as a condition where empathy leads to countertransference in therapists.
who are experiencing either a “temporary neurotic disturbance within [themselves]” or “in those who have a chronically precarious mental equilibrium” (p. 419). These countertransferences can either inhibit empathy on the part of the therapist, or result in the “loss of control of empathy” where the therapist is unable to differentiate his or her reactions from those of the client. For the therapist to engage in this process of merging and separating without the interference of countertransference reactions appears to require a stable sense of self with firm ego boundaries (Gorkin, 1987). This also requires that the therapist can put aside one’s own needs in the service of the client. The need for approval (Bandura, Lipsher & Miller, 1960) and the need to nurture (Mills & Abeles, 1965) have been shown to moderate therapist’s countertransference reactions. Therapists possessing these needs were more likely to display countertransference behavior toward their clients, suggesting that counselors who had yet to resolve these areas of personal conflict for themselves were less likely to manage their countertransference reactions productively.

The anxiety management factor refers to the extent to which the therapist is anxious in general (trait), as well as the tendency to experience anxiety in the therapy setting (state). That therapist anxiety occurs in the presence of strong client emotion, and that it is related to countertransference behavior, has been suggested by several studies (Beery, 1970; Gamsky & Farwell, 1966; Hayes & Gelso, 1990; Haccoun & Laviguer, 1979; Russell & Snyder, 1963; Yulis & Kiesler, 1968). Freud (1926/1959) thought that the ego will be called upon to defend itself against the danger signaled by the presence of anxiety, and findings from the above studies highlight some of the countertransference behaviors therapists employ to manage their own anxiety, such as withdrawing from personal involvement with the client, avoiding negative client emotion, or responding to negative emotion in a hostile or antagonistic manner. The better able therapists are in managing their anxiety adaptively in the presence of clients’ strong emotion, the less likely they will manifest countertransference behavior.

The last factor theorized by us to be important to countertransference management is conceptualizing ability, which refers to the extent to which the therapist can conceptualize the client dynamics in terms of the therapeutic relationship with the client, as well as in the context of the client’s past. Application of a theoretical framework to case conceptualization is considered a part of this factor. While the ability to conceptualize client material and behavior well is invaluable to the therapist in terms of guiding the work, it has also been shown to be a useful moderator of countertransference feelings toward clients. Robbins and Jolkovski (1987) found that reliance on a theoretical framework interacted with awareness of countertransference feelings to moderate therapist involvement, such that under conditions of low awareness of feelings, theoretical understanding resulted in emotional distancing from the client. When theoretical understanding combined with even moderate levels of awareness of one’s feelings, however, use of a theoretical framework facilitated involvement. The implication of Robbins and Jolkovski’s finding is that therapists who rely on theory in the presence of their own heightened awareness of countertransference feelings might be cognitively interpreting their feelings in a way that helps them remain therapeutically involved with the client. This process has been described as critically necessary (Reich, 1960) and potentially beneficial (Fromm-Reichmann, 1950; Gelso & Carter, 1985; Heimann, 1950) to the therapeutic endeavor.

As stated, our primary purpose was to determine if reputedly excellent therapists differed from therapists in general on these five ingredients theorized to be important to the management of countertransference feelings. A second general purpose was to assess if the particular theory of therapy relied upon by the reputedly excellent therapist relates significantly to qualities theorized to be important in countertransference management. Specifically, although psychodynamic, humanistic, and behavioral therapies are essentially equal in their global effectiveness (Lambert, Shapiro & Bergin, 1986), would therapists adhering to those orientations actually differ with respect to the possession of qualities thought to moderate countertransference?

Method

Participants

Two groups were combined to form the present sample. The first group consisted of 93 participants sampled randomly from the membership of Division 29 (Psychotherapy) of the American Psychological Association. The second group consisted
The Countertransference Factors Inventory (CFI) was mailed to the experts who were selected based on their extensive knowledge, scholarly writing, and/or empirical investigation in the areas of transference and countertransference. Eight of the eleven experts contained only subjects who had practiced, supervised, and/or empirically investigated personal counseling or psychotherapy within the last two years. The university sample was included so that personal follow-ups of their responses could be pursued for a later study. Nonsignificant differences between the university sample and the Division 29 sample on the dependent variables under investigation permitted combining both samples in the subsequent analyses.

Of the 122 subjects, 78 (63.9%) were female and 44 (36.1%) were male, with a mean age of 47.9 years. Clinical psychologists accounted for 64.8% of the sample, followed by counseling psychologists (23%), and other (11.4%) (e.g., psychiatrists, social workers). Ninety-six percent of the sample held a doctorate. The mean postgraduate experience conducting psychotherapy was 15.4 years (SD = 9.4), ranging from 1 to 51 years. On the average, participants spent slightly more than half of their professional activity conducting psychotherapy (mean = 51.8%, SD = 32.1), with the rest of their time devoted to teaching (mean = 7.9%, SD = 13.5), supervision (mean = 9.4%, SD = 9.0), empirical study (mean = 4.3%, SD = 8.4), and scholarly writing pertaining to counseling or psychotherapy (mean = 3.8%, SD = 8.1). Other professional activities accounted for a little less than one fourth of the subjects' professional time (mean = 23.4%, SD = 26.3).

We asked participants to rank order their theoretical orientation in terms of their belief in, and adherence to, Psychodynamic (e.g., Freudian, Sullivanian, Ego Psychology, Self Psychology, etc.), Humanistic (e.g., Rogerian, Existential, Gestalt, etc.), or Learning (e.g., Behavioral, Cognitive—Behavioral, Social Learning, etc.) perspectives. Subjects were not to tie any rankings. Of the total sample, 50% ranked psychodynamic theory as their primary theoretical orientation, followed by 23% learning theory, and 22% humanistic. The remaining 5% either tied their primary ranking or did not rank their orientation.

**Instruments**

**Countertransference Factors Inventory (CFI).**

The CFI is a 50-item, Likert type inventory designed for the present study to measure the extent to which therapists possess certain interrelated qualities or characteristics theorized to be important in the management of countertransference. These characteristics were conceptualized in terms of five rationally derived therapist factors (self-insight (e.g., "usually comprehends how his/her feelings influence him/her in the therapy"), "understands the background factors in his/her life that have shaped his/her personality"); self-integration (e.g., "effectively distinguishes between clients' needs and his/her own needs"); "is psychologically balanced") empathy (e.g., "is perceptive in his/her understanding of clients"); intuitively understands the clients"); anxiety management (e.g., "is comfortable in the presence of strong feelings from others"); does not experience a great deal of anxiety while conducting therapy); and conceptualizing ability (e.g., "often conceptualizes his/her role in what transpires in the counseling relationship"); "conceptualizes relationship dynamics in terms of the client’s past"). The CFI was subjected to a series of reviews and revisions by the authors, resulting in the fifty items selected for the final draft. Care was taken to ensure that each subscale contained a representative number of items sampling the domain of characteristics thought to be important in countertransference management. The five factors made up the subscales of the inventory. The number of items per subscale broke down as follows: insight, integration, and empathy (11 items each), anxiety management (8 items), and conceptualizing ability (9 items). It should be reiterated that the "factors" of the CFI were rationally derived rather than empirically derived. They were based on the authors' theoretical deductions, which in turn, were derived from the empirical and theoretical literature, as well as clinical experience. Content and face validity data, along with internal consistency reliability, are presented below.

Eleven experts in the areas of transference and countertransference were then selected to assess the content and face validity of the items. We selected these experts based on their extensive knowledge, scholarly writing, and/or empirical investigation in the areas of transference and countertransference. Eight of the eleven experts were male. Experts had mean age of 54.3 years (range 35–74), and as a group, averaged 22.9 years experience conducting postgraduate psychotherapy and 7 scholarly publications in the area of transference and countertransference. On the average they spent 35.3% of their professional time conducting psychotherapy.

The CFI was mailed to the experts who were asked to rate the importance of each item as it related to the management of countertransference.
The expert form of the CFI was in a 5-choice, Likert-type format, with alternatives ranging from "Not Important" to "Very Important." In the directions, experts were told that each item represented a characteristic "that a therapist might potentially possess that may or may not be critical in the management of his or her own countertransference reactions," and "assuming that all therapists experience countertransference feelings with their clients at one time or another," were asked to rate each characteristic as to how important they thought they were in the management of countertransference (1 = Not Important, 2 = Slightly Important, 3 = Somewhat Important, 4 = Important, 5 = Very Important). Return rate for the experts was 100% with one follow-up letter a month after the initial mailing.

Measures of central tendency were computed on the experts' rating of the CFI. All but 6 of the 50 items had a mean, median, and/or mode of 4 ("Important") or greater. Of the remaining six items, all had a mean, median, and mode of 3 ("Somewhat Important") or greater. These six items were distributed across all five subscales. Mean item scores and standard deviations, computed for each of the five subscales, were as follows: insight (mean = 4.09, SD = .45), empathy (mean = 3.89, SD = .59), conceptualizing ability (mean = 4.02, SD = .52), anxiety management (mean = 3.92, SD = .64), and self-integration (mean = 4.05, SD = .50). The mean item score for the total CFI was 4.01 (SD = .52). The mean item scores within each of the subscales and for the total scale suggest that the experts as a group found that the items reflect characteristics important to countertransference management, and that they accurately represented the domain for each of the five salient factors.

In addition to the CFI for experts, three additional forms of the CFI, varying only in the characteristics of the therapist that participants were asked to rate, were developed for subjects. Two of these forms asked subjects to "think of a normal distribution of therapists, with [their] concept of therapist-in-general as encompassing the middle of that distribution." They were then to identify either a male or a female therapist with whose clinical work they were familiar, and who they "would consider to be in the excellent range of this distribution," and then rate that person on the CFI. Ratings were on a 5-point Likert scale in terms of the extent to which participants agreed that the rated therapist possessed the given characteristic (1 = strongly disagree, 5 = strongly agree). The university participants were asked to rate either an excellent male or excellent female therapist. Two thirds of the Division 29 sample was also asked to rate either an excellent male or excellent female therapist. The remaining third of the Division 29 participants, however, was asked to "imagine the "therapist-in-general" conducting therapy, and rate him/her" on the CFI. (The CFI for subjects differed from the CFI for experts only with respect to the Likert type anchors and stems of the items, otherwise, the items were identical).

To assess reliability in terms of internal consistency, Cronbach's alpha was computed for the total CFI and each of the five subscales on the responses of the 122 subjects. For the total CFI, alpha was .97. For the subscales, alphas were: insight (.91), empathy (.92), conceptualizing ability (.88), anxiety (.91), and self-integration (.91). Before concluding our description of the CFI, two additional points need to be clarified. First, although we use the term "countertransference factors" in the inventory's title, it must be kept in mind that the CFI is not a direct measure of countertransference. Rather, it is a measure of an individual or group's status on five interrelated and rationally-derived factors theorized to be important (by the authors and expert judges) in the management of countertransference reactions. Might the five factors of the CFI be important to therapist operations other than countertransference management, e.g., overall therapist functioning? Undoubtedly the factors of integration, insight, anxiety management, empathy, and conceptualizing ability are related to a host of therapist behaviors. Yet the term countertransference factors is justified because the CFI is based on a theoretical formulation about countertransference, and the content and face validity data described above pertain directly to countertransference management.

The second point needing clarification pertains to the expected and actual interrelatedness of the CFI's five subscales. To begin with, in our theorizing of the five factors, we fully expected a relationship among them, with each factor generally contributing to the other in clinical practice, e.g., anxiety management, insight, and empathy are part of, contribute to, and are affected by self-integration. At the same time, we expected each factor to have sufficient non-overlapping variance to justify it as a separate construct. In fact, the data do support this conception of interrelatedness.
and separateness. The correlation coefficients for the largest subsample, those rating the excellent therapist (n = 91), were as follows for each pair of subscales: Conceptualizing Ability (CA) with Integration (Int) = .58; CA with Insight (Ins) = .54; CA with Anxiety Management (AM) = .31; CA with Empathy (EM) = .60; Int with Ins = .68; Int with AM = .71; Int with EM = .65; Ins with AM = .55; Ins with EM = .69; AM with EM = .51.

Procedure

Following several revisions of the CFI, subject packets were prepared for mailing, each containing a cover letter, demographic questionnaire, the CFI, a stamped, self-addressed envelope for returns, a postcard that could be used for requesting the results of the study, and a sealed envelope containing a brief explanation of the study. Participants were asked to first complete the CFI followed by the demographic questionnaire. Directions for the CFI were given on the first page of the inventory. Subjects were asked to rate on the CFI either: (a) their concept of a therapist in general; (b) a particular male therapist considered by the subject to be excellent in the field; or (c) a particular female therapist considered to be excellent in the field. Therapists from the Division 29 samples were randomly assigned to one of the above three conditions, while therapists from the university sample were randomly assigned to only the excellent male and excellent female conditions. Subjects who rated excellent therapists were instructed to select only a therapist with whom they have worked or observed. At the beginning of the CFI, they were to rank that therapist according to what they perceived the therapist's theoretical orientation to be. They were asked not to tie any rankings. In addition, they were to write the therapist’s name on a postcard provided for reference while rating that person on the CFI, so that raters would not inadvertently substitute other therapists throughout the task, and as a result, increase the likelihood of providing a more generic rating of their image of the excellent therapist. By asking subjects to visualize the actual therapist and imagine him or her conducting therapy, we hoped to remove some of the abstraction and tendency for subjects to fall into a perceptual “set” of some generic therapist. Following the rating they were asked to destroy the postcard with the therapist’s name on it to ensure the anonymity of the person being rated, place the demographic questionnaire and the CFI into the provided stamped, self-addressed envelope, and mail the packet back to us. They were then invited to open the provided envelope marked “Debrief,” containing a description of the study.

Two weeks after the initial mailing, a postcard reminder was mailed to nonrespondents, and four weeks following the initial mailing we sent another complete packet of materials to nonrespondents. Several steps were taken to ensure the maximum possible return rate. Cover letters were carefully worded expressing the value we placed upon participants’ time and input, and assuring that the anonymity of the participants was preserved, as well as the anonymity of the person they rated. The researchers personally signed all cover letters. In addition, study results were made readily available to participants. Finally, the “Debrief” was provided as an added incentive for completing the survey.

One participant returned the materials completed, but had indicated that he did not conduct psychotherapy. Of the remaining 189 participants surveyed, 122 returned the completed materials, resulting in a 65 percent rate of return.

Design

The overall design of the study was a levels-by-treatment, randomized blocks design. There were two primary independent variables. The main independent variable of the study, to which participants were randomly assigned, was degree of therapist excellence. This was divided into three levels: (a) excellent male therapist, (b) excellent female therapist, and (c) therapist in general. The second primary independent variable was the theoretical orientation of the excellent therapists selected for rating by the subjects, and this variable also contained three levels: (a) psychodynamic, (b) learning, and (c) humanistic. Gender of the participant was also analyzed to control for any possible systematic error due to this variable. Because theoretical orientation applied only to the excellent male and female therapists and not the therapist in general, the design was not completely crossed.

Results

Differences between the Samples

Because participants rating excellent therapists came from two sources, Hotelling $T^2$ tests for independent samples were performed comparing
the Division 29 and university samples' ratings of excellent therapists on the five subscales of the CFI. The Division 29 raters did not approach differing from the university sample on either their ratings of excellent male therapists ($T^2 = .17, p = .34$) or excellent female therapists ($T^2 = .11, p = .46$). As a result, the two samples were combined for all subsequent analyses.

**Gender, Excellence, and Countertransference Management**

Mean item scores, standard deviations, and a summary of post hoc univariate $F$ tests and Scheffe $t$ tests for the total CFI and the five subscales are presented in Table 1 based on the ratings of the excellent male and excellent female therapists, and the therapists in general. A two-way MANOVA was performed for participant's gender (male rater vs. female rater) by excellence (excellent male vs. excellent female vs. therapist in general) on the five subscales of the CFI. A significant and very large multivariate effect was found for therapist excellence using Wilk's criterion ($F[2, 116] = 9.77, p < .001$). No significant effects for participant gender or the participant gender by excellence interaction were detected. Follow-up univariate $F$ tests revealed that all of the subscales significantly contributed to the significant MANOVA effect (see Table 1). Scheffe's Multiple Range Test, the most conservative of the univariate posthoc procedures (Haase & Ellis, 1987), was employed to examine pairwise comparisons among the means of the three levels of the excellence factor on the total scores of the CFI, as well as the subscale scores, to determine where the differences between the three levels of excellence existed. The Scheffe procedure with the critical value set at $p = .01$ was used to minimize the build-up of the Type I error rate that occurs when multiple dependent variables are examined (Haase & Ellis, 1987). Post hoc comparisons revealed significant differences between ratings of excellent male therapists compared to therapists in general, and ratings of excellent female therapists compared to therapist in general; however, no differences existed between excellent male and excellent female ratings. Examination of the mean item scores in Table 1 highlights the direction of the differences between the groups. Clearly the excellent male and excellent female therapists were rated significantly higher on all of the subscales of the CFI, as well as the total CFI as revealed by a two-way ANOVA ($F[1, 116] = 49.33, p < .001$), in full support of our first hypothesis. There was no significant main effect for participant gender, nor was there a significant interaction effect between gender and excellence.

**Theoretical Orientation and Countertransference Management**

Mean item scores, standard deviations, and a summary of post hoc ANOVAs and Scheffe $t$ Tests for the total CFI and the five subscales are reported in Table 2 for the three levels of theoretical orientation.

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**TABLE 1. Ratings of Countertransference Factors According to Therapist Excellence. Means, Standard Deviations, and Post Hoc Univariate $F$ and Scheffe $t$ Tests of Excellence Differences**

<table>
<thead>
<tr>
<th>Countertransference Factors</th>
<th>Excellent Male $(n = 40)$</th>
<th>Excellent Female $(n = 51)$</th>
<th>Therapist in General $(n = 31)$</th>
<th>$F^a$ $(2, 116)$</th>
<th>Group Differences $^b$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>Conceptualizing Ability</td>
<td>4.29</td>
<td>.39</td>
<td>4.38</td>
<td>.46</td>
<td>3.52</td>
</tr>
<tr>
<td>Insight</td>
<td>4.08</td>
<td>.48</td>
<td>4.11</td>
<td>.51</td>
<td>3.20</td>
</tr>
<tr>
<td>Anxiety</td>
<td>4.32</td>
<td>.46</td>
<td>4.08</td>
<td>.66</td>
<td>3.27</td>
</tr>
<tr>
<td>Empathy</td>
<td>4.25</td>
<td>.43</td>
<td>4.38</td>
<td>.42</td>
<td>3.47</td>
</tr>
<tr>
<td>Total CFI</td>
<td>4.24</td>
<td>.43</td>
<td>4.24</td>
<td>.50</td>
<td>3.37</td>
</tr>
</tbody>
</table>

$^aF$ is based on post hoc ANOVAs for all of the CFI subscales.

$^b$Group differences are based on post hoc Scheffe $t$ Tests. M = Male; F = Female; and TIG = Therapist in General.

*p < .001.
TABLE 2. Ratings of Countertransference Factors According to Theoretical Orientation. Mean Item Scores, Standard Deviations, and Post Hoc Univariate F and Scheffe Tests of Theoretical Differences

<table>
<thead>
<tr>
<th>Countertransference Factors</th>
<th>Psychodynamic (n = 60)</th>
<th>Learning (n = 12)</th>
<th>Humanistic (n = 17)</th>
<th>F² (2, 116)</th>
<th>Group Differences</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>Conceptualizing Ability</td>
<td>4.45</td>
<td>.39</td>
<td>4.19</td>
<td>.43</td>
<td>4.09</td>
</tr>
<tr>
<td>Integration</td>
<td>4.30</td>
<td>.45</td>
<td>4.21</td>
<td>.45</td>
<td>4.19</td>
</tr>
<tr>
<td>Insight</td>
<td>4.18</td>
<td>.53</td>
<td>3.91</td>
<td>.42</td>
<td>3.97</td>
</tr>
<tr>
<td>Empathy</td>
<td>4.37</td>
<td>.45</td>
<td>4.21</td>
<td>.41</td>
<td>4.25</td>
</tr>
<tr>
<td>Total CFI</td>
<td>4.29</td>
<td>.49</td>
<td>4.13</td>
<td>.45</td>
<td>4.16</td>
</tr>
</tbody>
</table>

°F is based on post hoc ANOVAs for all CFI subscales.

b Group differences are based on post hoc Scheffe tests. P = Psychodynamic; and H = Humanistic.

* p < .05

** p < .01

orientation. Of the excellent therapists who were selected by participants, 60 were perceived as having a psychodynamic orientation, 12 as learning, and 17 as humanistic. To examine the second major hypothesis, that psychodynamic and humanistic therapists would be viewed more positively on the five salient factors than the learning therapists, a one-way MANOVA was performed on the subscales of the CFI, with the independent variable, theoretical orientation, consisting of 3 levels (psychodynamic vs. learning vs. humanistic). MANOVA revealed a significant multivariate effect, F [2, 116] = 2.11, p < .05. Univariate F tests revealed significant differences between the groups on the conceptualization subscale. Significant differences existed between ratings of psychodynamic therapists and humanistic therapists as revealed by Scheffe’s post hoc test (p = .01). Examination of the means in Table 2 indicates that psychodynamic therapists were rated more positively on conceptualizing ability than humanistic therapists. A one-way ANOVA on the total CFI score, however, revealed no significant differences between the theoretical orientations on an overall measurement of countertransference management.

Discussion

Excellent male and female therapists, when compared to therapists in general, were viewed as having more insight into their feelings and the basis for those feelings; as having a greater capacity for empathy in the sense of being able to partake of the client’s emotional experience, as well as having an intellectual understanding of client emotions; as being more highly integrated, and therefore, more able to differentiate client needs from their own needs; as possessing less anxiety in general and with clients in the session; and as being more adept at conceptualizing client dynamics, in both the context of the therapeutic relationship, and the client’s past.

While some studies have suggested that countertransference is inevitable, and that therapists respond to clients in predictable ways (Beery, 1970; Cutler, 1958; Gamsky & Farwell, 1966; Haccoun & Laviguer, 1979; Luborsky & Singer, 1974; Mueller, 1969), these findings taken at face value might be misleading. Excellent therapists, by virtue of their possession of more characteristics important to the management of countertransference than therapists in general, might defy the norm in that they are less likely to respond to client material, transference, or intense emotion in the predictable ways suggested by the research. Moreover, some studies support the notion that therapists do differ in their ability to manage countertransference. Therapists possessing a strong need for approval (Bandura et al., 1969) and need to nurture (Mills & Abeles, 1965), low or excessively high levels of empathy (Peabody & Gelso, 1982), low level of awareness of countertransference feelings (Robbins & Jolkovski, 1979), and heightened anxiety (Beery, 1970; Gamsky &
Farwell, 1966; Haccoun & Lavigueur, 1979; Russell & Snyder, 1963; Yulis & Kiesler, 1968), have been shown to exhibit greater amounts of countertransference behavior. Similarly, findings from the present study combined with the above research suggest that the generally excellent therapist, being more highly integrated, more empathic, and better able to manage anxiety than the typical therapist, in addition to being more insightful about his or her own feelings and conflicts, and more skilled in conceptualizing client dynamics, would be less likely to manifest countertransference behavior, thus maximizing his or her capacity for responding to clients constructively. Given an understanding of how excellent therapists differ from the norm with respect to the above characteristics, therapists in training, as well as experienced therapists, might strive to model what excellent therapists do in therapy, and not assume that the norm is what everybody does or even should do.

Another implication from the findings is that it may be wise for therapists to seek therapy for themselves if they truly are to minimize the impact of countertransference on their work. Such personal therapy would appear to make sense, especially since the five ingredients we have theorized as important in countertransference management may well be affected by personal therapy. For example, Strupp (1973) found that experienced therapists who had undergone personal therapy were more responsive and empathic to the needs of their clients. We would likewise expect that factors such as self-insight, anxiety management, and self-integration to be positively affected by personal therapy.

Although excellent therapists from the three theoretical orientations did appear to differ overall on the five subscales of the CFI (see the MANOVA results), subsequent univariate analysis revealed that the only significant effect by theoretical orientation was between the excellent psychodynamic therapists and the excellent humanistic therapists on the subscale, Conceptualizing Ability. Excellent psychodynamic therapists received higher ratings on the subscale than excellent humanistic therapists. Neither the psychodynamic nor the humanistic therapists differed as predicted from the excellent learning therapists on any measure.

The difference between excellent psychodynamic and humanistic therapists on conceptualizing ability does make sense when one considers the differential value placed upon conceptualizing in these two approaches. Psychodynamic theory places a premium on conceptualizing client dynamics and the therapeutic relationship, especially with regard to transference and countertransference (Gelso & Carter, 1985). Humanistic theory, on the other hand, places a premium on experiencing in the moment, and on living within the experience of the therapeutic moment. The therapist is to encounter the client subjectively, rather than think about the client during the hour (Meador & Rogers, 1984; Polster & Polster, 1973; Rogers, 1980).

It will be recalled that the large majority of the excellent therapists that participants selected to be rated in the study were of a psychodynamic orientation (i.e., 60 of 89, or 67%). Although this imbalance does not cause serious problems in terms of the validity of our quantitative analysis, it does appear to add an important twist to how the findings may be interpreted. Thus, although excellent psychodynamic, learning, and humanistic therapists differ little in terms of ingredients that are seen as important in countertransference management (except for conceptualizing ability), when a sizeable sample of psychotherapists is asked to rate an excellent therapist, the therapist who is chosen is quite typically a psychodynamically oriented therapist. The 67% figure is well beyond the percentage of the participants who rate themselves as psychodynamic (50%). Why so many of the excellent therapists chosen for rating in this study were dynamic remains an interesting question awaiting future research.

The above discussion notwithstanding, it appears that in general, excellence overrides theoretical orientation in terms of the ingredients that facilitate countertransference management. While learning theorists have not traditionally focused a great deal of attention on the therapeutic relationship, and in particular, their own reactions to clients (Messer, 1986), they (at least those reputed to be excellent) do appear to possess characteristics that would theoretically help them manage their countertransference reactions. Moreover, there appears to be emerging importance placed on the therapeutic relationship in behavior therapy (Goldfried, 1982; Lazarus, 1981; Meichenbaum & Gilmore, 1982), even resulting in some behavior therapists examining their reactions to clients (Goldfried & Davison, 1976). Given this trend, we may expect to see learning therapists attending to the therapeutic relationship more and more, and possibly to their own reactions to their clients within that relationship. While excellent learning therapists might not emphasize countertransference awareness as
important in the delivery of therapy, they equal psychodynamic and humanistic therapists in their perceived possession of factors that might help them manage countertransference feelings.

A potential limitation of the present study is that raters might have had a perceptual "set" for excellence dictating that excellent therapists would be rated highly on everything. This would be consistent with the social psychology literature demonstrating that people will be perceived in a way that is congruent with a particular schema or stereotype (Hamilton, 1979). On the other hand, excellent therapists might, in fact, possess more of the characteristics measured. The fact that we had the raters visualize the therapist they rated doing therapy should have removed some of the abstraction of the task, and attenuated the perceptual set problem. Future research might explore the influence of cognitive sets on ratings of excellent therapists.

A second limitation pertains to the fact that data were gathered by asking experienced therapists for their perceptions of the imagined excellent therapist and the therapists in general. Such perceptions are important in and of themselves, but much caution must be exercised in generalizing from perceptions to the actual behaviors of excellent therapists. Finally, although we believe that there are therapists who generally excel in their work, the master therapists so to speak, it is also likely that no therapist is highly effective with all types of clients. A therapist who is excellent with one group may not be effective with another. Thus, within the concept of overall excellence, we would expect considerable therapist by client variability in therapist effectiveness.

In conclusion, the results do suggest that excellent therapists are perceived to possess more qualities theoretically related to the management of countertransference than therapists in general. That this is the case regardless of the theoretical orientation of the excellent therapists requires further investigation. It should be stressed that the results do not indicate directly that excellent therapists are in fact better than therapists in general at managing countertransference, although that certainly would be a reasonable inference. The next steps in the research would be to determine if excellent therapists actually do more effectively manage their countertransference reactions, as well as to assess directly if our five theorized factors related to actual countertransference feelings as we have theorized and as our expert judges support? Moreover, is the management of these feelings related to treatment outcome? There is considerable support to suggest that therapy, overall, is equally effective for all the major theoretical schools (Lambert, Shapiro & Bergin, 1986). Perhaps the key to their success lies in the existence of non-specific factors common to all techniques that positively influence outcome (Kazdin, 1986). Research does suggest that relationship factors are powerful determinants of therapeutic success (Lambert, Shapiro & Bergin, 1986). That countertransference management might be a by-product of therapist possession of general qualities important in all therapeutic endeavors, independent of theoretical orientation, requires further investigation.

References


Countertransference and the Reputedly Excellent Therapist


