

Pennsylvania State University
The College of Education
Department of Educational Psychology, Counseling and Special Education

**USING THE CORE CONFLICTUAL RELATIONSHIP THEMES (CCRT)
METHOD AS A COUNTERTRANSFERENCE CODING TECHNIQUE**

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Matthew C. Johnson

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The dissertation of Matthew C. Johnson reviewed and approved* by the following:

Jeffrey Hayes
Program Coordinator of Counseling Psychology
Chair of Committee, Dissertation Advisor

Kathleen J. Bieschke
Department Head of Educational Psychology

Louis G. Castonguay
Professor at Department of Psychology

Joyce Illfelder-Kaye
Director of Training at Center of for Counseling and Psychological Services

*Signatures are on file in the Graduate School

Abstract

This study assessed the utility of the Core Conflictual Relationship Theme (CCRT) coding method, a method commonly utilized in the coding of transference as a method for coding countertransference (Luborsky, 1998). Though a few studies have used the CCRT as a measure for coding countertransference manifestations, most have used the CCRT as a means to an end (to examine therapist attachment, to compare therapist reactions to patients with different diagnoses, etc.) and none have held validating the CCRT as a viable countertransference coding method as their central focus. Thus, this study sought to answer three central research questions: First, can the CCRT coding system be used to identify a therapist's countertransference template? Second, once extracted, will a therapist's CCRT become evident throughout the course of therapy? Third, in regard to Gelso and Hayes' (2007) integrative definition of countertransference, will a therapist's CCRT only be activated with certain types of clients who provide an activating unresolved conflictual issue stemming from the therapist's past and/or a therapy related event that provoked a countertransference manifestation? Results suggested that using the traditional RAP interview to extract the therapist's transference template worked regarding the therapist's transference template, but the form that the CCRT took during 14 audio-recorded therapy sessions was extremely limited and perhaps more socially acceptable, given the therapeutic context, than those seen in more intimate relationships. This finding could support Freud's premise that transference templates manifest "with respect to the individual's external circumstances, and the nature of what the available love objects will sanction" (1912/1958a p. 312-313).

Additional results suggested that partial expressions of the CCRT may become active during the therapeutic session, specifically wishes (W) and responses to self (RS). Finally, the identification of origins, or unresolved conflictual issues was possible through the utilization of the CCRT coding method expressed in the manner of wishes (Ws), but there was little evidence that the identification of therapy related events that “triggered” countertransference manifestations, in the form of responses from others (ROs), were expressed or captured using the method.

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Chapter 1

Introduction

The first recorded use of the term “countertransference” occurred during one of the most infamous moments in the history of psychology. Upon learning of an affair that had occurred between Carl Jung and his patient Sabina Spielrein, Freud, who had been previously consulted on the case as both a confidant and mentor, attempted to be supportive of his friend and colleague during the precarious ethical situation in which he found himself (Haynal, 1996). In a letter dated June 7th, 1909, Freud wrote:

Such experiences, though painful, are necessary and hard to avoid. Without them, we cannot really know life and what we are dealing with. I myself have never been taken so badly, but I have come very close to it a number of times and had a narrow escape. I believe that only grim necessities weighing on my work, and the fact that I was ten years older than yourself when I came to psychoanalysis, have saved me from similar experiences. But no lasting harm is done. They help us to develop the thick skin we need to dominate “counter-transference,” which is after all a permanent problem for us; they teach us to displace our own affects to best advantage. They are a “*blessing in disguise*” (p. 230-231).

One year later Freud would publicly present his ideas on the countertransference (“Güngenbetrang” in German) phenomenon at the Second International Psychoanalytic Congress at Nuremberg. However, the presentation was far from the final word on countertransference manifestations, and the concept itself became shrouded in mystique and complexity. In fact, though able to name the phenomenon, Freud was utterly perplexed with certain aspects of countertransference, including the intensity of feelings

experienced in failed clinical cases (Freud & Abraham, 1965). In a 1913 letter to Binswanger, Freud asserted that though easier to settle theoretically, countertransference was one of the most problematic technical issues within psychoanalysis. Thus, Freud restricted his technical suggestions to cautious and “essentially negative advice” (Haynall, 1996). In a later letter to Ferenczi, Freud clarified his position: “I thought that the most important thing was to underline what should not have been done and to highlight the temptations that might put the analysis in jeopardy” (Jan. 4, 1928). Yet, while Freud attempted to address beginning analysts with simplistic formulations, later analysts would highlight the confusion and seemingly contradictory nature of Freud’s technical papers regarding the phenomenon. Eventually, this would lead to the challenging of the “classical” definition of countertransference itself.

While initial challenges to Freud’s technical explanation of the phenomenon opened the field of psychoanalysis to a bevy of conceptualizations, the diffuse range of suppositions also attenuated the theoretical explanation, technical applicability, and overall clinical utility of the construct. Fauth (2006) has identified two central problems with the modern concept: 1) the lack of conceptual precision within the field of psychotherapy regarding the construct, and 2) the lack of appropriate measures to capture the rich complexities intrinsic within the concept of countertransference itself. Within the last 25 years, however, there has been a renewed interest in the concept itself as well as in the interaction it may have with other therapeutic relationship factors (e.g., Epstein & Feiner, 1988; Gelso & Hayes, 2007). Most recently, the work of the APA’s Division 29 (Division of Psychotherapy) Task Force has restated the need for conceptual clarity,

regarding both the concept's theoretical definition and technical efficacy (Norcross, 2011).

From this renewed interest, which has examined both the historical and contemporary divergences, there now seems to be a few points of widespread agreement (Gelso & Hayes, 2007). At present, countertransference is considered by most clinicians and researchers to be a joint creation of the therapist and patient (Gabbard, 2001). It is also widely agreed upon by those within the psychoanalytic/psychodynamic orientation (as well as much of the psychotherapy community), that a patient will inevitably attempt to make the therapist a transference object and the therapist must therefore work methodically to disentangle him/herself from the transference/countertransference dynamic (Gabbard, 2001; Gelso & Hayes, 2007). Furthermore, there is a consensus among a majority of the psychoanalytic community that it is technically impossible to work from a "blank screen" perspective as was once advocated (Gelso & Hayes, 2007, p. 7). Finally, while the direct effects of countertransference are murky, contemporary research suggests that countertransference manifestations are related inversely and modestly to therapeutic outcomes (Hayes, Gelso, & Hummel, 2011). It is believed that this might be possible because countertransference reactions can damage the therapeutic alliance and therefore possesses the ultimate potential of negatively affecting therapeutic outcome (Smith, Barret, Benjamin, & Barber, 2006).

Yet, while it is generally agreed upon that countertransference manifestations can be potentially detrimental to therapeutic outcome, and that therapist factors explain up to 9% of the variability regarding psychotherapy outcome, the best ways to identify, isolate, and examine the countertransference experience have remained enigmatic, at best (Gelso

& Hayes, 2007; Wampold, 2001). One reason for this difficulty is that countertransference manifestations are considered to be partially or fully unconscious in nature, and therefore routinely exist outside of a therapist's awareness (Gelso & Hayes, 2007). For this reason, in conjunction with the extremely personal nature of countertransference manifestations, historical methods of countertransference research, including the utilization of self-reports, have been deemed particularly unreliable.

Kiesler (2001) has posited that if we as researchers are to properly understand countertransference, we must first "take the time to assess the necessary behavioral baselines for therapists and their clients" (p 1053). Additionally, Gelso and Hayes (2007) have stated that the goal of countertransference research is to "discover nominal laws that might apply to more than single cases" (p.114). Thus, the predicament of countertransference research up to this point might best be summarized by synthesizing the two aforementioned ideas: namely, what new method should researchers use to circumvent the historically unreliable methods of data collection in hopes of discovering generalizable information about countertransference?

One possible answer to the above-mentioned question is the Core Conflictual Relationship Theme (CCRT) coding method (Luborsky, 1998). By using the CCRT, a traditional transference coding method that extracts transference templates through the coding of therapeutic narratives, many of the shortcomings exhibited in previous methodologies are potentially bypassed. Additionally, the multidimensional nature of the CCRT coding system is seemingly in accordance with Gelso and Hayes' (2007) emphasis on finding research procedures that can examine interactions between patient dynamics and therapist variables in hopes of learning more about how countertransference reactions

are activated within individual therapists, as well as what it is about particular patients during specific moments in therapy that cause that therapist's activation.

Initial research findings using the CCRT to identify countertransference reactions have been promising. Using the CCRT-LU (Leipzig/Ulm method) Bourke and Grenyer (2010) compared therapists' perceptions of, and subsequent reactions to, patients diagnosed with major depressive disorder (MDD), with those diagnosed with borderline personality disorder (BPD). Findings suggested that the therapists studied seemed consistent in their desire to support those patients suffering from MDD while assisting the development of independence in those patients diagnosed with BPD (Bourke & Grenyer, 2010). Showing the multidimensional nature of the CCRT, the researchers were also able to examine therapeutic perception (Bourke & Grenyer, 2010). Patients with MDD were viewed by the therapists as providing consistently "harmonious" relational responses whereas those patients with BPD were seen as expressing discordant reactions or "negative responses from others" (Bourke & Grenyer, 2010, p. 686). Also, the most commonly displayed responses by the therapist toward the patient was one of support, which as Bourke and Grenyer (2010) have posited, may have to do with the initial advancement of relational empathy towards patients regardless of their specific therapeutic diagnosis.

Tishby, Wiseman, and Vered (2010) also attempted to examine countertransference with the CCRT method in therapist-client dyads. Participants consisted of two therapists and two patients who were monitored across three time points in a year-long psychodynamic psychotherapy. Utilizing Hayes' (2004) operational model of countertransference, which identifies origins, triggers, manifestations, effects, and

management, Tishby et al. (2010) attempted to link the CCRT (a means of studying the origins of countertransference and effects on process) as indicated by changes in working alliance, changes in post-session questionnaires, and changes in OQ-45 scores with countertransference manifestations that occur during the therapeutic hour.

Countertransference manifestations included the following CCRT components:

identification with the parent, repair of the parent, reaction to patient as parent, and distancing/withdrawal in response to countertransference content. Results indicated that therapist' CCRTs with parents can alter their perceptions of their clients, and affect their selection of particular interventions when countertransference is triggered during the therapeutic hour (Tishby et al., 2010).

Wiseman and Tishby (2010) also used the CCRT in conjunction with attachment theory in hopes of better understanding the interplay between interpersonal patterns, working alliance, and therapeutic outcome. Utilizing session material from 60 therapeutic dyads, the researchers examined the individual characteristic patterns that therapists and patients bring to the relationship and how these patterns interact with one another during different phases of therapy. Results indicated that the specific interplay between the CCRTs of therapists and patients play out according to the specific dyad's dynamics. For instance, deactivation of a therapist's attachment system was viewed as related to CCRT themes of distancing and ambivalence while hyperactivation of CCRT themes were viewed as a wish for closeness and seeing the other as distant.

Finally, Tisby and Vered (2011) utilized the CCRT coding method to examine the countertransference manifestations of 12 female social workers who conducted psychodynamic therapy. Similar to the Tishby, et al. (2010) study, Tishby and Vered

(2011) extracted the CCRT from participating therapists' narratives regarding his/her parents and then examined countertransference manifestations within session. Results indicated that there was a high repetition of parental themes in narratives about patients for all three components of the CCRT (Wish, Response of Other, and Response of Self). Additionally, more validation was given to the findings of the Tishby et al. study (2010) by a qualitative analysis of generated therapist narratives, which included repeating the actions of the parent, repairing the actions of the parent, identification with the patient, and distancing (Tishby & Vered, 2011).

To date, the CCRT has demonstrated great potential as a possible solution to the problem of how countertransference might be measured more accurately. However, despite the previously mentioned CCRT countertransference studies, there remains a paucity of evidence regarding the ability of the CCRT to accurately measure countertransference. For instance, in a majority of the aforementioned studies the CCRT was used as a means to some other end: to examine therapist attachment, to compare therapist reactions between patients with different diagnoses, etc. None of the previously mentioned studies held validating the CCRT as a measure of countertransference as their primary focus. Therefore, a step backwards must be taken if clinicians and researchers are to consider the CCRT as a valid countertransference measure.

Thus, this study considers to what extent the CCRT coding method is capable of capturing countertransference origins and manifestations by thoroughly examining the speaking turns of a therapist during the therapeutic hour. Additionally, in regards to Gelso and Hayes' (2007) integrative definition of countertransference, this study hopes to provide examples of how a therapist's CCRT can be activated with certain types of

patients who elicit the necessary activating “hooks,” or “triggers.” As Tishby and Vered (2011) point out, if the CCRT continues to prove itself as a reliable and valid countertransference coding method, it may be the answer to Gelso and Hayes’ (2007) call for the field of psychotherapy research to unearth “sophisticated ways of capturing the often unconscious roots of countertransference reactions” (p. 127).

Chapter 2

LITERATURE REVIEW

This review of the literature aspires to provide a history of the countertransference construct from both a theoretical and empirical perspective. Additionally, this review of the literature intends to examine the Core Conflictual Relationship Theme (CCRT) method, commonly utilized in the coding of transference templates and subsequent transference manifestations within the therapeutic setting, as a possible coding system for countertransference templates and subsequent therapeutic manifestations. Due to the fact that the CCRT originated as a transference measure, and there have only been minimal attempts at coding countertransference templates and manifestations using the CCRT method, this review first investigates the concept of transference from both a historical and contemporary vantage point. This is then followed by a brief overview of studies that have used the CCRT as a transference measure in hopes of displaying the measure's versatility and overall utility. At that point, an exhaustive review of the theoretical and empirical literature on countertransference is presented. Finally, a review of the minimal research using the CCRT method as a countertransference measure is discussed.

Before continuing, the reader should be made cognizant of a few considerations taken by the author while writing this review. First, despite originating in a predominantly psychoanalytic context, the constructs of transference and countertransference have spanned a wide-range of theoretical orientations under different monikers. Thus, in many instances constructs typically defined as "transference" and "countertransference" have been referred to by different names despite sharing similar meanings. Often this has been due to the specific language used in various theoretical

conceptualizations. For instance, even before Freud (1912/1958a) coined the term “transference” the idea had been historically alluded to by the hypnotist Janet (1919/1976), who described and referred to a similar phenomenon as “influence,” “adoption,” and “electivity” (as cited in Haule, 1986). Since Freud’s official naming of the transference phenomenon, similar concepts have also emerged such as Sullivan’s (1953b) “parataxic distortions,” Blos’s (1941) “residual traumas,” and Freeland and Wheeler’s (1963) “nuclear conflicts,” to name a few.

While perhaps frustrating for the reader, the case for renaming transference and countertransference phenomena is not without warrant. As will be shown in this review, historically the terms transference and countertransference have been used indiscriminately despite referring to very different ideas (Gelso & Hayes, 2007; Sandler, 1976;). This review will therefore attempt to identify this past confusion before selecting definitions of transference and countertransference believed by the author to provide clarity and definition to otherwise diffuse terms. It must be noted, however, that for the purposes of this section, findings will be reported and discussed in the original language of their authors.

THE CONSTRUCTS

The objective of this section is to enhance the reader’s theoretical clarity concerning the constructs known as transference and countertransference. Thus, starting with the construct of transference, this section will provide a historical overview of the construct, followed by a review of the contemporary literature on the topic. This will be followed by a description of historical attempts at objectively measuring the construct before familiarizing the reader with the Core Conflictual Relationship Theme coding

method (CCRT). It should be clarified that while this chapter will provide an overview of the coding method, chapter 3 will explain the more technical aspects of the method in detail.

Similar to the transference construct, the countertransference construct is then introduced by providing a historical and contemporary synopsis of the construct's theoretical development. This is followed with a description of historical countertransference research while expounding the need for better methodologies. Finally, an exhaustive review of the initial CCRT countertransference studies is conducted.

Transference

In hopes of promoting a more comprehensive understanding of the concept of countertransference, and the nature of this particular study, it is first imperative to develop a thorough historical and contemporary understanding of the concept of transference. The reason for this is twofold: 1) This study hopes to examine the possible use of a common transference measure, the CCRT, as a countertransference measure and (2) Transference reactions can directly impact countertransference manifestations. As Gelso and Hayes (1998) affirm, "client transference and therapist countertransference reciprocally influence one another, and this interaction has a significant impact on process and outcome" (p. 106). Thus, this section offers a detailed description and explanation of the concept, followed by a chronological timeline of its conceptual evolution. Empirical attempts to measure the construct will then be discussed before concluding with a brief overview of how the CCRT coding method is utilized as a transference measure.

Description

Approximately 100 years ago Freud (1912/1958a) established the usage of the term transference in a paper entitled, *The Dynamics of Transference*. Since then, the concept has become arguably the crown jewel in Freud's many contributions to the theoretical comprehension of the human psyche. Though many of Freud's other contributions have been scorned and/or discounted, with criticisms leveled towards his ideas ranging from them being non-falsifiable to allegations of pure mysticism, transference, though no less mystifying, has retained its importance. In fact, since its inaugural usage the term has spread in its conceptualization and importance from the realm of psychoanalytic literature into general psychotherapy literature, and is now consistently seen as a natural occurrence among seasoned therapists.

Transference, properly understood, is a phenomenon that occurs within the therapeutic relationship, that is, between the patient and therapist, and can be described as the patient's tendency to express behaviors and/or attitudes which developed from early conflictual relationships with significant or primary caregivers towards the therapist (Freud, 1912/1958a; Luborsky, Crits-Christoph, Mellon, 1986). However, since Freud (1912/1958a) first used the term "transference," the concept has taken on so many theoretical extensions that its definition has become somewhat diffuse. In a theoretical examination of the concept, Sandler (1976) reported that the term "transference" has expanded from its original definition into one that has included the treatment alliance, indicated an infantile repetition of the past within treatment, encompassed transference of defense and externalization, included all thoughts, attitudes and fantasies related to the

therapist, represented all aspects of the patients relationship to the therapist, and signified an externalization of a current but internal object relationship by the patient.

Thus, before continuing it may be helpful to give a historical overview of the concept and its various developments. In the late 1800's the hypnotist Pierre Janet, a student of Jean-Martin Charcot (who would later train Freud in hypnotic application), began to comprehend that the roots of therapeutic rapport were dissociative in nature (Haule, 1986). Janet (1919/1976) referred to the dissociative therapeutic alliance situation as an "act of adoption" by the patient who is unable, due to dissociative restriction, to perceive anyone but his or her own therapist (p. 1154). Throughout the course of his work, Janet (1919/1976) also referred to the phenomenon as "influence," or "electivity" when describing a patient's peculiar preference for his/her personal therapist (p. 1155). Janet (1919/1976) writes, "We have to assume that at a certain moment in their treatment the patients have formed in their minds the special tendency towards the person who was specially interested in them. We can speak of the moment, of this remarkable action as an "act of adoption" (p. 1154). This "magnetic passion," according to Janet (1898/1925), could be seen in the types of loving feelings expressed by the patient, including those which are filial, maternal, or erotic in nature (see also Gay, 2006). Freud also recognized this "magnetic passion" with early hysterical patients he treated using hypnosis (Gay, 2006). In one particular case, Freud recalled that after alleviating hysterical symptoms via hypnosis, the patient quite embarrassingly threw her arms around his neck. He would later cite this as the "mystical element" intrinsic within hypnosis (Gay, 2006, p. 50).

During the time of Janet, a physician by the name of Josef Breuer was working with a woman by the name of Bertha Pappenheim (Gay, 2006). Pappenheim, commonly

referred to as “Anna O.” would later become one of psychology’s most famous patients for her pivotal role in the advancement of psychoanalytic theory. Yet while her treatment is often credited with the creation of the cathartic method, the insight into the transference situation also proved invaluable to the history of psychoanalytic theory development. So much so, that Freud (1914/1958) would later refer to the intense client-doctor connection generated through Breuer and Pappenheim’s use of the use cathartic method as a “complete prototype of transference” (p.12).

Though the case of Anna O. was first documented in 1895 in Freud’s *Studies on Hysteria*, it actually took place in 1880, when the young Pappenheim became ill after her father died (Gay, 2006). Among her reported symptoms was weakness, change in appetite, nervous coughing, a noticeable squint, partial paralysis, mental lapses, hallucinations, etc. Using hypnosis, Breuer observed that Anna O. was able to trace each symptom back to the occasion from which it had started and thus “talk away,” their existence. However, years later, in a letter written by Freud (1932) to Stefan Zweig, Freud stated that Breuer had entrusted him with the information that during the night of Anna O’s deliverance from all of her symptoms, Breuer was again called for, only to find her writhing in pain from abdominal cramps. When asked about them she replied, “Now comes Mr. B.’s child” (as cited in Gay, 2006, p. 67). Horrified, Breuer immediately discontinued treatment with Anna O. and repeatedly vowed never to undertake such an ordeal again. It was Freud’s (1893/1955), belief that this was a manifestation of an unanalyzed positive transference and the reason that Breuer waited so long to publish the case (see Strachey footnotes, p. 41).

However, although Freud's (1895/1955) first official use of the term transference appears in *The Psychotherapy of Hysteria* where he details how the patient will "transfer" onto the therapist through a "false connection," it was an extremely contracted way of looking at the phenomenon which he would later expand upon with great detail (p. 303). By 1905, in *The Interpretation of Dreams*, Freud would allude to the phenomenon as a transfer of intensity and energy from an unacceptable unconscious idea onto an idea in the preconscious in order for it to become more acceptable. Freud (1905/1953) would reportedly tell a patient that the "earliest experiences of childhood were 'not obtainable any longer as such,' but were replaced in analysis by 'transferences' and dreams" (p.184).

However, while the abovementioned usages of the word "transference," are certainly related to the concept we now think of within the therapeutic setting, it takes little time to recognize that though related, they are fundamentally different from how the term would later be used by psychotherapists. In 1912 Freud greatly clarified the concept in his technique specific paper entitled, *The Dynamics of Transference*. In it he posited that every individual, through a combination of innate disposition and early environmental influences obtains a particular method of conduct regarding his/heir erotic life, which contains the requisites for falling in love which he/she has for a partner, the instincts he/she gratifies, and the aims he/she positions during the course of it (Freud, 1912/1958a). This combination of factors, according to Freud (1912/1958a), creates a single, or perhaps several templates that will constantly be repeated throughout the course of an individual's life with respect to external circumstances, and the nature of what available love objects will sanction. Freud (1912/1958a) was also clear that these templates were not entirely rigid and were therefore susceptible to change based on

experience. The developmental explanation within the theory of transference was that during psychological development some libidinal impulses, which later establish an individual's erotic life, pass through an entire process of psycho-sexual development (Freud, 1912/1958a). Those libidinal impulses that successfully navigate the respective psycho-sexual stages of development are aimed towards reality, are at the beckon of the conscious personality, and form a part of it (Freud, 1912/1958a). In contrast, those libidinal impulses which are unsuccessful in their navigation of the developmental stages and processes become stuck, remain distant from consciousness and reality, are prevented from further expansion, and as a result, with the exception of fantasy, remain completely unconscious (Freud, 1912/1958a). Accordingly, when an individual's need for love is not entirely fulfilled by the situation he/she faces in reality, then he/she will approach every new object with libidinal interest; and it therefore becomes likely that both the conscious and unconscious libidinal impulses from an individual's psycho-sexual development play a role in the forming an individual's erotic attitudes (Freud, 1912/1958a). It then naturally follows, according to Freud (1912/1958a), that the libidinal cathexis of the unsatisfied patient will naturally seek out other individuals, including the figure of the doctor, and appearing much like earlier prototypes, will "introduce the doctor into one of the psychological 'series' which the patient has already formed" (p. 100). Thus, Freud's (1912/1958a) original conceptualization of the true transference phenomenon involved two distinct components: 1) a structural component referring to the mental representation of interpersonal relationships and 2) a procedural component referring to the application of this mental representation to guide interpersonal perception (Connolly, Crits-Christoph, Demorest, Azarian, Muenz, & Chittams, 1996).

Conceptual Evolution

According to Luborsky (1998a) Freud postulated the following 23 ideas concerning the concept of transference:

1. The “instincts,” “aims” and “impulses” that a person wishes to satisfy are prominent in an individual’s transference pattern.
2. Wishes towards others conflict with responses from others and responses to self within the transference template.
3. The central relationship is especially evident in erotic relationships.
4. The central relationship pattern is partly out of awareness.
5. The central relationship pattern originates in early relationships with early parental figures.
6. The central relationship affects the relationship with the therapist.
7. The central relationship can be activated by similarities the patient perceives in the current relationship in the therapeutic situation.
8. The central relationship pattern may distort perception.
9. The concept of the transference template emphasizes that there is one main relationship pattern.
10. Specific sub patterns appear for each family member.
11. The central relationship pattern is distinctive for each narrator.
12. The central relationship pattern tends to be consistent over time.
13. The central relationship pattern changes slightly over time.
14. The central relationship pattern shows short-term fluctuations in activation.
15. Interpretation changes the expression of the central relationship pattern.

16. Insight into the central relationship pattern can benefit the patient.
17. The central relationship pattern can serve as a resistance.
18. Symptoms may emerge when the pattern is activated.
19. The pattern expressed within therapy is similar to the pattern expressed outside of therapy.
20. Positive and negative patterns are distinguishable.
21. The pattern is expressed similarly through different expressive modes.
22. Greater improvement in dealing with the pattern implies greater mastering of the pattern, although the pattern itself remains evident.
23. Innate disposition plays a part in creating the central relationship pattern (p.309).

As pointed out by Luborsky (1998a), Freud's 23 observational statements regarding the nature of transference, which seem to have been empirically based on Freud's own clinical experiences, supply a theoretical basis for its "origin, function, and activating" principles as well as information about the stimuli that may minimize or control its expression (p. 322). However, the sundry nature of the observations makes them difficult to logically categorize as a "set" of transference characteristics (Luborsky, 1998a, p. 322). It is therefore no wonder that since Freud, the concept of transference has become a loaded term, full of meaning and theoretical extension (Makari & Michaels, 1993). Due to these extensions, which are perhaps attributable to the diffuse nature of Freud's 23 observations, the term has since lacked theoretical clarity (Makari & Michales, 1993). As Laplanche and Pontalis (1973) point out, in some arenas the term

transference has come to denote all phenomena within the patient-therapist interaction. In Sandler, Dare, and Holder's (1992) revised version of 'The Patient and the Analyst' six distinct usages of the term transference were identified and examined:

- 1) Reference to the patient-therapist alliance
- 2) A suggestion of an unconscious repetition of the patient's infantile past within treatment
- 3) To refer to a transference of defense and externalization
- 4) Reference to the patient's thoughts, attitudes and fantasies regarding the therapist
- 5) In reference to all aspects of the patient-therapist relationship
- 6) In reference to an externalized internal object relationship that is currently occurring in the patient's life.

Some theorists have expanded on and/or noticeably moved Freud's (1912/1958a) original definition of transference from the patient's transfer of attitudes and behavior from early conflictual relationships with parental figures onto his/her current therapist. For example, in an attempt to bring attention to the act of speech as the vehicle for all transference manifestations, Lacan (1954/1991) posited that transference occurs whenever there is meaningful speech between two individuals, that is, a symbolic transference which fundamentally alters the nature of the two individuals who are speaking. Additionally, attachment theorists have examined the importance of

transference as a way of understanding a patient's internal working model of attachment (Bowlby; 1973, 1979, 1988).

More recently, transference has been examined from a visual standpoint. Advancing from the premise that the face offers a bevy of insight regarding both the perceived and perceiver, Kraus and Chen (2010) have looked at the face as a stimulus for transference manifestations. This may lend itself to other theoretical inferences about ethnocultural and racial transference (Comas-Diaz & Jacobson, 1991; Yi, Kris Y., & Holmes, D., 1992).

Several psychoanalytic theorists have defined similar concepts to Freud's (1914/1958) transference template (Luborsky & Crits-Christoph, 1998). Describing something similar to the unresolved conflict portion in the Freudian definition of transference, Blos (1941) labeled it a "residual trauma." Analogous to the idea of the single (or perhaps several) template(s) Freud (1912/1958a) mentioned in the original definition, Freeland and Wheeler (1963) put forth the concept of a single "nuclear conflict" within a patient. Arlow (1961, 1969a, 1969b) also described a strong single theme in an individual's life where his/her fantasies are clustered around certain primitive wishes, and in an attempt to resolve his/her intrapsychic conflict regarding these wishes thus produce different adaptations of these fantasies over the course of an his/her life. Arlow (1961) writes, "The organization of these fantasies takes shape early in life and persists in this form with only minor variations throughout life. To borrow an analogy from literature, one could say the plot line of the fantasy remains the same although the characters and the situations may vary (p.47)."

In sum, since Freud's (1914/1958b) conceptualization of transference as a repetition of the patient's forgotten past (conflictual attitudes and behaviors) onto the contemporary therapist, transference has taken on many theoretical extensions. As previously highlighted, this may be due to the diffuse nature of the 23 original observations of Freud, which though methodical, lent themselves to a more phenomenological rather than precision-based definition. Additionally, further elaborations on the concept, though helpful in an examination of the phenomenon as a whole, have nevertheless pushed the concept from its original definition to the edge of murkiness, and as a consequence have reduced the terms overall utility.

Measurement

Despite a profound theoretical presence, for many years quantitative attempts to explain the transference phenomenon were at best, substandard (Luborsky, Crits-Christoph, & Mellon, 1986). Much of the poverty within the initial research can be attributed to a lack of conceptual sophistication, which in turn failed to measure the concept represented in the long-standing theoretical model (Luborsky et al., 1986). As Luborsky et al. (1986) point out, psychotherapy transference research has typically been conducted two ways: (a) questionnaires and (b) psychotherapy process measures. While early questionnaires proved to be valiant initial attempts to operationalize the concept of transference, they tended to lack conceptual precision (Luborsky et al., 1986). However, the recent shift in methodological focus from questionnaire measures to psychotherapy process measures has served as a conduit for more expansive ways of thinking about the concept.

As stated previously, early research regarding the transference phenomenon tended to utilize a questionnaire methodology. However, the intrinsic struggle within in this type of research revolved around the development of a valid operational version of the transference concept that also captured the phenomenon depicted within the historical theoretical literature (Luborsky & Crits-Christoph, 1998). Chance (1952) created a questionnaire measure that compared the resemblance of the patient's depiction of a significant parent with the patient's account of the therapist (Luborsky & Crits-Christoph, 1998). Fielder and Senior (1952) also attempted to operationalize the transference concept by comparing the patient's depiction of his/her "ideal self" with the patient's forecast of the therapist's self-description in conjunction with similar measures completed by the therapist (as cited by Luborsky & Crits-Christoph, 1998). These initial attempts at capturing the occurrence of transference, though noble, failed to preserve the breadth of the concept within the typical clinical framework and were therefore largely disregarded (Luborsky & Crits-Christoph, 1998).

Another issue surrounding early attempts at operationalizing transference was that psychotherapy researchers tended to use the methodological form of the Q-sort (Apfelbaum, 1958; Crisp, 1964a, 1964b, 1966; Rawn, 1958, 1981; Subotnick, 1966a, 1966b). Though this sort of inquiry into the transference phenomenon has been both viewed as inadequate by much of the psychotherapy research community, and also as problematic due to the intrinsic problems within self-report measures, the author of the current study deems it important to briefly mention some of the earlier empirical inquiries into the transference concept so that the reader might fully appreciate both the need and range of the CCRT measure.

Apfelbaum (1958) endeavored to tap the transference phenomenon by using a Q-sort to scrutinize a patient's expectations regarding the therapist he/she would later be assigned to. Patients within the study were then grouped according to three separate types of expectations: therapist will give nurturance, therapist will be a model, or therapist will be a critic (as cited in Luborsky et al., 1986).

Rawn (1958, 1981) also used the Q-sort methodology to examine four sessions of a patient's personal analysis. He then compared the results with clinical observations before identifying likeness between the two (Luborsky & Crist-Christoph, 1998). This procedure, which utilized clinical observation to identify similarities with other measures, is of particular importance to the current CCRT countertransference study for at least two reasons: 1) It has been historically atypical within transference research, especially when using self-report methods, to utilize clinical observation as a comparison method with the primary method of inquiry. 2) It may show researchers how to correctly utilize self-report measures regarding the transference measure so that in the future they might be utilized to triangulate with other research findings (Luborsky & Crits-Christoph, 1998).

Crisp (1964a, 1964b, 1966) continued in the same vein of research by studying both the patient's view of the therapist and father figures in hopes of estimating the amount of transference during therapy sessions (as cited in Luborsky, et al., 1986). Interestingly enough, one of Crisp's (1964a, 1964b, 1966) findings suggested that attitudes towards the therapist changed with, or were precursory flags to coming changes in, patient symptomology (Luborsky, et al., 1986). This finding might be in line with the classical analytic idea regarding the development and subsequent usage of the patient's transference.

Subtonic (1966a, 1966b) employed two sets of Q-sorts to identify attitudes towards parents and therapists during various times over the course of therapy (Luborsky et al, 1986). Findings suggested similarity between patient attitudes towards parent and therapist (Luborsky et al., 1986).

However, as was previously alluded to, like most questionnaire measures, the Q-sort method was criticized as ineffective due to questionable validity and thus fizzled out as the primary option of for studying transference manifestations (Luborsky et al., 1986). Additionally, along with other validity issues, several scholars have noted that the questionnaire method will always be insufficient when examining transference occurrences because of its inherent inability to distinguish appropriate attitudes from inappropriate attitudes by the patient towards the therapist, which is usually considered a requisite characteristic of the traditional analytic transference concept (as cited in, Luborsky et al., 1986). Nevertheless, in an attempt to answer the need for a questionnaire measure that could be compared with transference measures that were based on actual psychotherapy sessions, Barber, Foltz, and Weinryb (1998) attempted to create a questionnaire supported by the central relationship pattern seen within the clinical context. This measure has shown promise regarding the utilization of the self-report measure to capture the stable construct of core conflictual patterns.

This being said, due to the aforementioned limitations of the self-report method, and the fact that the concept of transference was originally observed within the realm of psychotherapy, studying actual sessions of psychotherapy has recently gained momentum within the psychotherapy research community and is largely considered to be a more viable methodology when assessing transference (Luborsky, Crits-Christoph, &

Mellon, 1986). Common methodologies used within this “process approach” include systematic clinical formulations, rating methodologies, and content coding methodologies (Luborsky et al., 1986).

Systematic Formulations

Systematic formulations, which adopts the word “formulation” to denote a patient’s central relationship pattern, were commonly used by a team from the Menninger Foundation Psychotherapy Project (Wallerstein, 1985; Wallerstein & Robbins, 1956) in an attempt to locate “formulations” by examining therapists’ termination summary notes in conjunction with patient, therapist, and patients’ relatives interviews (as cited in Luborsky, Crits-Christoph, & Mellon, 1986).

The Chicago Consensus Group (Seitz, 1966) also executed a study using free discursive formulations of the transference concept by independent assemblies of therapists (as cited in Luborsky, et al., 1986). Though a lack of agreement was found among the formulations, as Luborsky et al. (1986) point out, any finding would have been difficult to substantiate due to the study’s lack of objectivity regarding the comparison formulations of different raters.

The Mayman and Faris (1960) formulation system was founded on the idea that clinical recognition of general rudiments across a few early patient memories was possible (Luborsky, Crits-Christoph, & Mellon, 1986). This method is still seen as a vital precursor to present day methods such as the CCRT (Luborsky, et al., 1986). However, despite the measure’s historic importance, it failed to adequately define principles for conducting clinical judgments and/or producing estimated reliability (Luborsky, et al., 1986).

The fundamental idea that there is a stable set of relationship patterns which are consistent over the course of an individual's lifetime is a premise contained in script theory (Luborsky, Crits-Christoph, & Mellon, 1986). Carlson (1981) describes Tomkin's (1979) idea of a script as "the individual's rules for predicting, interpreting, responding to, and controlling experiences governed by a 'family' of related scenes" (p. 502). Tomkin's (1979) script theory also identifies one or a few "nuclear scene(s)" that exist under the aforementioned guidelines (as cited in Luborsky et al., 1986).

Rating Methods

Though more accurate than questionnaire methods, agreement within clinical formulation methods can be difficult to obtain, which can perhaps be attributed to a range of different clinical understandings regarding transference manifestations by individual clinicians (Luborsky, Crits-Christoph, & Mellon, 1986). To circumvent this issue, rating inquiries, which are measures that rate the "amount" of transference experienced in a given session, have also been used as a common methodology (Luborsky et al., 1986). The first rating methods were limited to examining the amount of transference rather than the type of transference (Luborsky et al., 1986). Using an early rating method Strupp, Chassan, and Ewing (1966) found little agreement among five independent raters who rated the amount of transference within psychotherapy sessions (Luborsky et al., 1986). Evaluating five, 30 minute sessions of one individual's analysis, The Analytic Research Group of the Institute of the Pennsylvania Hospital (Luborsky, Graff, Pulver, & Curtis, 1973) found that agreement was low ($r = .26$) when the amount of transference in a segment was the only phenomenon examined. Agreement was higher for segments rated for probable transference, ($r = .46$, $p < .01$) when judgment was related to amounts of

conveyed transference in relation to each individual person within the segment (Luborsky et al., 1973). The research group also found that those segments with higher amounts of rated transference displayed much more affect than did those that did not (Lower, Escoll, Little, & Ottenberg, 1973). Additionally, by performing a factor analysis on the ratings of 23 transference-related concepts, the concept “space,” which was used by each of eight analytic raters, could be identified reliably (Luborsky, Crabtree, Curtis, Ruff & Mintz, 1975). Finally, consistency over time was found on post session checklists of transference and resistance regarding four patients, two who improved and two who displayed no evidence of improvement (Graff & Luborsky, 1977). The improved patients showed an increased pattern of transference, which could suggest that revisions are called for regarding the typical notion that successful cure within analytic treatment calls for the eradication of transference (Luborsky, Crits-Christoph, & Mellon, 1986).

Content Coding Methods

More than the previously mentioned methods of measuring transference, two content coding methodologies, known as the Patient’s Experience of the Relationship With the Therapist Method (PERT), and the Core Conflictual Relationship Theme Method (CCRT), have been widely accepted as more viable measures of the historically accepted clinical concept of transference (Luborsky et al., 1986). Unique to these coding methods, clinicians are required to follow set procedures rather than freely formulating whatever categories they find most appropriate (Luborsky et al., 1986). Though both methods attempt to examine aspects of transference, the difference between the two methods is that the PERT attempts to approximate the regularity of the patient’s experience of the relationship with the therapist while the CCRT examines the regularity

and content of the patient's individual core conflict within the therapeutic setting (Luborsky et al., 1986). However, it must be noted that though the PERT and CCRT are the only two content coding methods described here, they are not the only measures to do so in this manner (Luborsky & Crits-Christoph, 1998). In fact, in *Understanding Transference*, Luborsky and Crits-Christoph (1998) isolated at least 16 additional measures that have been created after the creation of the CCRT coding method and attempt to measure a concept similar to the core conflictual theme within an individual. Thus, the reason for the selection of the CCRT and PERT in this particular section is that the central measure of this paper, that is, the CCRT is often compared to the PERT and has traditionally used the PERT as a validity measure (Luborsky & Crits-Christoph, 1998).

The PERT

Gill and Hoffman's (1982) creation of a transference-like coding scheme examines and utilizes data directly from transcribed audiotaped psychotherapy sessions in hopes of illuminating patient communications regarding the therapeutic relationship. The Patient's Experience of the Relationship With the Therapist Method, or the PERT, is a coding method that offers instructions for registering the amount of communications from the patient about his/her explicit relationship with the therapist as well as implied indications about the experience (Luborsky, Crits-Christoph, & Mellon, 1986). The method also includes an evaluative component regarding the extent to which a therapist's particular interventions impact the chief aspects of both the covert and noticeable aspects of the therapeutic relationship (Luborsky & Crits-Christoph, 1998). The coding method itself is directly derived from a viewpoint that the therapist, as actor is understood to be a

significant codeterminant source of transference manifestations (Gill, 1982; Hoffman, 1983). In discussing the difference between the PERT and the CCRT, Gill and Hoffman (1988b) stated that the PERT is “more geared toward the tracking, not only of transference themes, but also of resistance as it affects nuances of communication during the course of the session” (pp. 92-93).

The CCRT

In classical analytic theory, Freud (1914/1958) recommended that the physician permit the patient time to comprehend his/her transference resistance. Freud (1914/1958) writes, that to “work through” the transference an analyst need to do nothing more than wait and allow the treatment to run its course which “cannot be avoided, nor always hastened” (p.155). This process of both letting the therapist and patient wait for the transference themes to emerge is time and labor intensive. In the contemporary times of managed care and short term therapies, waiting for this sort of information has shown to be a luxury that very few individuals and companies can afford.

While attempting to examine the therapeutic alliance, Luborsky (1976) asked the question that many interpersonal therapists have attempted to theoretically address for years, that is, what does the relationship pattern as seen in therapy look like when examined within the broader fundamental pattern of relationships? By examining general relational patterns within the therapy setting through the extraction of narratives from psychotherapy session transcripts, recurrent interactions were identified and isolated (Luborsky & Crits-Christoph, 1998). Upon further examination Luborsky (1998b) noted that three components of interaction continually came into light; what the patient wanted from other people, how the other people reacted, and how the patient reacted to their

reactions. Component categories were identified and tested and the method was named the Core Conflictual Relationships Theme Method (CCRT) (Luborsky & Crits-Christoph, 1998).

The CCRT appeared to act in accordance with Freud's (1912/1958a) stereotype plate definition of transference with the special benefit of providing an able system for supplying inferences about an individual's reoccurring relationship template(s) (Luborsky & Crits-Christoph, 1998). In other words, similar to the inferences that experienced psychotherapists make regarding transference patterns, the CCRT is able to make inferences about transference patterns with more concrete principles for the declared suppositions (Luborsky & Crits-Christoph, 1998). Thus, the routine function of the therapist during the session to make inferences about a patient's transference template now had the empirical means to justify his or conclusions (Luborsky & Crits-Christoph, 1998). Additionally, by using the CCRT coding method an individual's basic transference template(s) can be extracted and stated explicitly as the focus of a short-term therapy (For a list of possible template components see Appendix B). While it may take time to "work through" as Freud (1914/1958) suggested, extracting and using the CCRT as the focal point of therapy eases the time intensive process of traditional analytic therapy.

Method

To utilize the CCRT coding method, therapy sessions should first be recorded and transcribed (Luborsky & Crits-Christoph, 1998). The CCRT method can then be divided into two different phases: Phase A involves the location and identification of Relationship Episodes (RE's), and Phase B is the extraction of the Core Conflictual Relationship

Theme, comprised of three components (i.e. wishes, responses from other, and response to self), from transcript narratives (Luborsky & Crits-Christoph, 1998).

During the first phase of the CCRT method a group of raters often referred to as the relationship episode or “RE” raters, read over an entire session transcript. Upon reading the transcript, the RE raters examine the text and demarcate relationship episodes (Luborsky & Crits-Christoph, 1998). A relationship episode, or RE, can be defined as a common narrative incident that a patient often tells while in therapy (Luborsky, Crits-Christoph, & Mellon, 1986). Common narratives or relationship episodes involve people the patient is closest to (family, friends, boss, therapist, etc.) in their everyday lives (Luborsky, et al., 1986). In each RE a main person is identified other than the patient (Luborsky & Crits-Christoph, 1998). There is no problem if multiple people are identified within a narrative as long as there is one main “other” (Luborsky & Crits-Christoph, 1998). Like a true narrative within the realm of literature, a complete relationship episode’s length is marked by having a beginning, middle, and end (Luborsky & Crits-Christoph, 1998). The RE raters have an additional task of rating each relationship episode on a scale of 1 to 5 for completeness. For examples of relationship ratings for completeness, see Appendix C. See the methods section for more detailed instruction regarding the CCRT process. A minimum of ten relationship episodes rated over 2.5 in completeness is traditionally required to move into Phase B of the scoring method (Luborsky & Crits-Christoph, 1998).

Upon identification and demarcation of the REs in a transcribed session, another set of coders, commonly referred to as the CCRT coders or judges, read over the REs (Luborsky et al., 1986). The CCRT judges then independently identify the following

three components: (a) the patient's wishes, needs, or intentions (W), (b) responses from others (ROs), and (c) the responses of self (RSs) (Luborsky & Crits-Christoph, 1998). Using a standard scoring system, which will be described in detail in chapter three, each of the three CCRT components, Wishes (W), Responses from Other (RO), and Responses of Self (RS) are identified for the highest frequency across all available relationship episodes.

The CCRT is expressed by highlighting the most common or recurrent Ws, ROs, and RSs across the narratives (Luborsky & Crits-Christoph, 1998). Each CCRT judge is independent and unaware of the other judges' responses (Luborsky & Crits-Christoph, 1998). According to Luborsky and Diguier (1998) an adequate interrater reliability coefficient typically ranges from .61 to .70. In accordance with Freud's transference hypothesis, individuals consistently display one (or perhaps several) consistent transference templates within therapy, and across the lifespan. Barber, Luborsky, Crits-Christoph and Diguier (1995) have reported that those CCRTs extracted during early psychotherapy sessions are comparable to those after termination.

Regarding validity, the CCRT has been assessed two different ways. The first way the CCRT has been tested for validity has been to compare CCRT component (W, RO, RS) changes from early to late treatment phases with other independent measures designed for testing therapeutic outcomes (Luborsky, Mellon, Alexander, van Ravensway, Childress, Levine, Cohen, Hole, & Ming, 1985). Hypothesizing that change in an individual's CCRT from early to later phases of treatment should be related to independent treatment measures, Luborsky et al. (1985) compared the change scores of CCRT components in eight subjects with the Hopkins Symptom Check List total score

(from the perspective of the patient) and the Health-Sickness Rating Scale (from the perspective of an external rater). Change in the pervasiveness of the central negative response to self (RS) showed a significant correlation with change in the Health-Sickness Rating Scale, $r(6) = .81, p < .05$, as did change on the main wish, $r(6) = .73, p < .05$. Positive change regarding the central RO showed significant correlation with change on the Hopkins Symptom Checklist $r(6) = .79, p < .05$. This being said, it should be noted that these correlations are likely inflated due to the small sample size.

Another way the CCRT has been validated has been through the comparison of the CCRT with other measures such as the PERT measure (Gill & Hoffman, 1982a), The Plan Diagnosis Method (Weiss, Sampson & The Mount Zion Psychotherapy Research Group, 1986) and the Dynamic Focus Method (Schacht & Binder, 1982). CCRT researchers have also attempted to validate the measure by comparing it to Teller and Dahl's (1981) language based analysis system for psychotherapy as well as Horowitz's (1979) configurational analysis.

RAP Interviews

In hopes of isolating an individual's CCRT if he/she is not in therapy, or if psychotherapy is not available, Luborsky (1998c) developed the relationship anecdote paradigm interview (RAP). The RAP interview uses an interview format, and produces narratives similar to those found in psychotherapy sessions (Luborsky & Crits-Christoph, 1998). In a comparative study between narratives that appear during psychotherapy sessions with those that appear in the Relationship Anecdote Paradigm (RAP) interview the agreement between two raters examining psychotherapy transcripts and using the clustered standard categories was 94% for wishes (W), 100% for responses from other

(RO) and 88% responses of self (RS). The corresponding weighted kappas were .81 for wishes, (W), .64 for responses from other (RO), and .73 for responses of self (RS). In the narratives found within the RAP interview the percentage of agreement between two independent raters was 84% for wishes (W), 100% for responses from other (RO) and 89% for responses of self (RS). The corresponding weighted kappas were .68 for wishes (W), .60 for responses from other (RO), and .65 for responses of self (RS) (Luborsky & Diguier, 1998).

During a RAP interview the narrator is asked to describe any relationship episode, past or present, that involved actual events with other people (Luborsky, 1998c). The narrator is encouraged to describe the episode concretely and to include a sample of the conversation with the other person (what the narrator said, what the other person said, and what happened at the end of the interaction). A typical RAP interview is 30-50 minutes long and consists of approximately 10 episodes (Luborsky, 1998c). Additionally, the RAP interview necessitates the client to relay narratives between themselves and others (Luborsky, 1998c). Luborsky (1998c) noted that RAP interviews “can be used for assessing a range of development, intellectual, and cultural qualities” (p.136). The traditional instructions for the RAP interview process are as follows:

Please tell me some incidents or events, each involving yourself in relation to another person. Each one should be a *specific* incident. Some should be current and some old incidents. For each one tell (1) when it occurred, (2) who was the other person it was with, (3) some of what the other person said or did and you said or did, (4) what happened at the end, and (5) when the event in the narrative happened. The other person might be anyone --- your father, mother, brothers and sisters, or other relatives, friends or people you work with. It just has to be about a specific event that was personally important or a problem to you in some way. Tell at least ten of these incidents. Spend about three but no more than five minutes in telling each one. I will let you know when you come near to the end of five minutes. This is a way to tell about your relationships. Make yourself

comfortable and engage in this RAP session as you would with someone you want to get to know you (Luborsky & Crits-Christoph, 1998, p. 110).

Countertransference

Like transference, the term countertransference (“Gügegenbetrag” in German) has held a long and diffuse existence within the psychotherapy literature. Freud (1910/1959) first publicly used the term in an address given at the Second International Psychoanalytic Congress at Nuremberg entitled, *The Future Prospects of Psychoanalytic Therapy* where he implored fellow analysts to recognize and overcome the ‘countertransference’ that arose within them as a result of the patient’s influence on their respective unconscious feelings. This insistence upon overcoming countertransference manifestations stemmed from the analytic consensus that no analyst could help a patient progress further than his/her own complexes and resistances would allow (Freud, 1910/1959). In the same address Freud emphasized the point by stating that “anyone who cannot succeed in this self-analysis may without more ado regard himself as unable to treat neurotics by analysis” (1910/1959, p.289). Freud therefore originally advocated for all analysts to undergo a thorough self-analysis that would continue even during the analytic hour. However, Freud (1914/1958) would later recognize the inherent limitations within self-analysis and for a time vacillated between the sufficiency of self-analysis and the need for a formally conducted analysis by another as the most efficacious way to manage one’s personal countertransference reactions. Eventually, Freud (1937/1950) would seemingly resolve the matter in *‘Analysis Terminable and Interminable’* by remarking that every practicing analyst should periodically reenter his/her own analysis for examination. Unfortunately, this fluctuation between the adequacies of self-analysis with an analysis by another was one of the more minor issues surrounding the concept

and in a 1913 letter Freud wrote that despite being easier to theoretically resolve, countertransference was one of the most difficult technical problems within psychoanalysis (Binswanger, 1957).

These “technical difficulties” Freud (1913/1957) alluded to within the 1913 letter are easily observed when attempting to summarize his conjectures surrounding the phenomenon (p. 50). While most of his instructions for the analyst interested in mastering countertransference reactions point to the Socratic axiom, ‘Know thyself,’ others seem to suggest avoidance of feelings and reactions altogether. The perplexities of this technical conflict can perhaps best be observed in a 1912 paper where Freud made a statement that would be taken by the field of psychotherapy, albeit perhaps incorrectly, from a place of self-reflection and insight, towards an area of avoidance and cold, surgical precision (Gelso & Hayes, 2007). Freud (1912/1958a) writes:

I cannot recommend my colleagues emphatically enough to take as a model in psychoanalytic treatment the surgeon who puts aside all his own feelings, including that of human sympathy and concentrates his mind on one single purpose, that of performing the operation as skillfully as possible. Under present-day conditions the feeling that is most dangerous to a psycho-analyst is the therapeutic ambition to achieve by this novel and much disputed method something that will produce a conscious effect upon other people. This will not only put him into a state of mind which is unfavorable for his work, but will make him helpless against certain resistances of the patient, whose recovery, as we know, primarily depends on the interplay of forces in him. The justification for this emotional coldness in the analyst is that it creates the most advantageous conditions for both parties: for the doctor a desirable protection for his own emotional rite and for the patient the largest amount of help that we can give them to-day. A surgeon of earlier times took as his motto the words: ‘Je le pansai: Dieu let guerit’ (“I dressed his wounds, God cured him.”). The analyst should be content with something similar (p. 327).

Put simply, Freud (1912/1958a) urges fellow analysts to put aside their sympathetic feelings and emotions in favor of logical calculation. The reason for this is twofold: 1) To avoid the ‘most dangerous condition’ of trying to provide convincing

cures to the masses which might prove powerless against certain resistances that align nicely with the arrogance of “the perfect cure”; 2) To provide the doctor with healthy emotional boundaries while giving the patient therapeutic space to mature. Freud’s (1912/1958a) final sentence in the quote, in conjunction with the previous importance placed on the “interplay within” the patient seems to suggest that he ultimately believed that the best an analyst can do, and therefore should be content with, is to provide a consistent treatment or “dressing” to the psychological wounds that only God or, in the case of Freud, human resiliency, can miraculously heal.

However, when discussing technique further, Freud (1912/1958a) would also suggest within his writings that an analyst “bend his own unconscious like a receptive organ towards the emerging unconscious of the patient, be as the receiver of the telephone to the disc” (p. 328). These two quotes (i.e., surgeon, telephone) seem to denote subtle differences in emotional activity on the part of the analyst. In the first quote, which followers and critics alike have often read as a declaration of inhumane coldness, therapeutic distance is essential in providing the analyst with healthy boundaries while giving the patient room to heal. Conversely, the second quote advocates for the analyst to actively use his/her unconscious as a tool for understanding the analysand’s unconscious. It might therefore be argued that while these quotes often serve as a battleground for arguments concerning Freud’s stance on empathy towards the patient (especially when reading the surgical quotation), it is actually more accurate to depict the differences in these remarks as questions surrounding emotional activity. In essence, the question that comes to the forefront when comparing these quotes is whether a therapist should be cold and precise, moving with the calculation of a surgeon

extracting a psychic cancer; or one that allows his/her unconscious to merge with the unconscious of the patient in order to listen to what is really being conveyed during the therapeutic hour. The third possibility, which admittedly has the potential to be paradoxical in nature, is the idea that inaction and action might somehow be reconciled by arguing for simultaneous activity on the part of the analyst. In other words, if it is possible for an analyst to remain “surgical enough” to promote boundaries and maturational space while simultaneously remaining “receptive enough” to sift through the unconscious material being transmitted by the analysand, there need not be an accusation of contradiction. While some of the aforementioned explanation of theory is mere speculation, we do know that Freud did not adhere to the rigidity of the surgical quote. In fact, when considering the differences within the perceived meaning of the quotes, in combination with the historical understanding we now have regarding the relationships Freud had with some of his patients, one must seriously ask whether or not he ever advocated for coldness on the part of the analyst (Gay, 2006). Regarding Freud’s admonitions of countertransference manifestations, Gay writes, “These frigid images state Freud’s case with a chilling finality that some of his other texts, and even more his practice, partially invalidate. We have seen him bending his rules and at times breaking them, with a sovereign sense of mastery and in the interest of sheer humaneness. He remitted the fees of his analysands when they fell on hard times. He allowed himself cordial comments during the hour. He made friends with his favorite patients. He conducted, as we know, informal analyses in some astonishing settings; analyzing Eitingon during evening strolls through Vienna is only the most spectacular of his

informal experiments. But in his papers on technique Freud allowed himself not a hint of such escapades (pg. 303).”

Regardless of intention, however, the perceived incongruity within these quotes proved damaging and would consequently take years to rectify. Most of the early analytic field accentuated the cold, neutral portions of Freud’s surgical quote while utterly ignoring his given justifications or future corrections. Overall, the historical conceptualization of the phenomenon is now viewed as convoluted and inconsistent due to idea that countertransference manifestations were seen as both a hindrance to therapy and a tool used for understanding the patient (Epstein & Feiner, 1988; Gelso & Hayes, 2007).

Thus, the conceptualization of countertransference that was originated by Freud is commonly referred to as the “classical view” of countertransference and can be defined as the “therapist’s largely unconscious, conflict-based reactions to the patient’s transference” (Gelso & Hayes, 2007, p. 5). In other words, countertransference manifestations derive from unresolved conflicts from a therapist’s early childhood and are elicited by the patient’s transference (Gelso & Hayes, 2002). From this conceptualization countertransference may include both neurotic and nonneurotic components, but it is the neurotic components that make it adverse to the therapeutic situation (Gelso & Hayes, 2007).

While the contradictions intrinsic within Freud’s (1910/1959, 1912/1958a, 1914/1958b) theoretical statements caused many to shy away from the concept, the groundwork for future elaboration was always present and fertile. One of Freud’s earliest colleagues, Sandor Ferenczi (1919) first pointed out that Freud’s conjunctions regarding

countertransference were contradictory in nature by pointing out that earlier statements advocated for the suppression of an analyst's feelings and emotional states while later writings were much more tolerant of the analyst's use of his/her unconscious to better comprehend what was occurring in the patient's unconscious (Ernsberger, 1979).

Viewing these contradictions as problematic when considering technical application, Ferenczi (1919) attempted to neutralize the damaging portions of the "surgical precision" quote by declaring that restriction of an analyst's personal affects may obstruct his/her ability to apply his/her own unconscious during the treatment. This insight was essential to the resurgence and development of the concept because it did not substitute a therapist's desire for clinical precisions with untamed passion, but instead managed to put forth a more humanistic viewpoint than Freud (1910/1959) by suggesting that doctors, like patients, are human and therefore susceptible to the same "moods, sympathies and antipathies, as well as impulses," and only because of this are they potentially able to understand the patient sitting across from them (p. 97). In accordance with this declaration, Ferenczi (1919) instructed that an analyst must both examine the patient by identifying the unconscious properties of the patient's psyche displayed in the patient's various forms of communication, while controlling his/her own personal attitudes towards the patient. Ferenczi thus concluded that through personal analysis and constant self analysis within sessions the analyst may be able to identify and separate from any extreme feelings that might cross therapeutic boundaries. If examined closely, Ferenczi's (1919) declarations were not so much theoretical departures from Freud (1912/1958a) as they were an attempt to refocus on the idea that an analyst should "bend his unconscious like a receptive organ" towards the unconscious transmissions of the analysand (p. 328).

While Ferenczi (1919) was definitely one of the first analytic theorists to acknowledge the usefulness of countertransference manifestations, there is debate as to whether he fully understood the implications of his statements (Balint, 1942; de Forest, 1942; Ernsberger, 1979). What is likely is that Ferenczi (1919) did understand that patients often transfer similar feelings to the analyst as those seen in an indulgent mother, stern father, or both; and that depending on the particular therapeutic context the therapist's behavior and responses should be, at various times and for identified reasons, in line with that of the original transference template, or in direct opposition to it (Ernsberger, 1979). This idea would later serve as the precursor for Alexander's (1961) "corrective emotional experience," which is often espoused in modern analytic psychotherapy. Ferenczi (1919) would also become the first analyst to advocate for self disclosure as well as confessing to mistakes as valuable components of psychoanalytic technique (Ernsberger, 1979).

Yet another important idea regarding countertransference that Ferenczi (1919) championed and which has now become a contemporary viewpoint in some analytic circles, is that patients who hold certain diagnoses can produce certain feelings and attitudes in the analyst that are not due to unresolved conflicts within the analyst, but are induced by the patient directly (Ernsberger, 1979; Kernberg, 1965; Winnicott, 1949). This conceptualization of countertransference is now regarded as a precursor of what is often referred to as the "totalistic view." This viewpoint of countertransference manifestations can be defined as "all of the therapist's attitudes and feelings toward the patient" (Gelso & Hayes, 2007, p. 7).

While the classical view of countertransference dominated the field of psychoanalysis for many years, the totalistic viewpoint gained momentum around the 1950's when psychoanalysts expanded treatment to include different types of pathologies, including schizophrenia (Gelso & Hayes, 2007). Proponents of the totalistic definition argue that the classical view of countertransference is limited in its scope and does not encapsulate the true importance of perhaps the most critical tool of research into the patient's unconscious, that is, the emotional responses given by the therapist to the patient within the analytic situation (Heimann, 1950). This reason for this definition's gained popularity among psychoanalytic circles occurred because countertransference began to be conceptualized less as a hindrance and more of an internal helper that could aid the therapist in a better understanding the patient (Gelso & Hayes, 2007). The theory behind this new utilization of the concept was that by studying one's internal reactions the therapist will likely pick up important information: 1) they will better understand how others in the patient's life respond to his/her interpersonal pulls; 2) they may begin to understand the patient's transference (Gelso & Hayes, 2007).

In addition to this advancement of definition, the therapist's own analysis took on more meaning (Ernsberger, 1979). Instead of being a way to battle or understand countertransference feelings as Freud (1937/1950) suggested, a therapist's individual analysis took on an increased role of importance by promoting the development of the unconscious as a therapeutic tool (Ernsberger, 1979). Paula Heimann (1950) became a spokesperson for this position by stating that the purpose of an individual analyst's personal analysis was not to create a cold, unfeeling brain that would produce completely intellectual interpretations but should be instead used to facilitate the analyst's ability to

sustain induced feelings in order to employ them for the needs demanded within the future therapeutic task.

This illuminates one of the more interesting yet problematic pieces intrinsic within the totalistic definition; that of the role played by emotional induction from patient to therapist (Ernsberger, 1979). Heimann (1950) writes, “From the point of view I am stressing, the analyst’s countertransference is not only part and parcel of the analytic relationship, but it is the patient’s creation, it is part of the patient’s personality” (p. 83). Unlike the criticism of “magical projective identifications” leveled at other definitions of countertransference, emotional induction within the totalistic view proclaims a necessary reciprocity or interplay between two individuals when engaged on a therapeutic level (Balint & Balint, 1939; Jung, 1935/1972; Spotnitz, 1999).

In hopes of further explaining countertransference from a totalistic view, proponents have differentiated between objective and subjective countertransference manifestations (Spotnitz, 1999). In a paper entitled, *Hate and the Countertransference*, Winnicott (1949) discussed the therapist’s objective reactions to the patient, which he instructs must be separated and examined (Spotnitz, 1999). In special cases, Winnicott (1949) goes as far as to say the therapist must be able to objectively hate the patient. The idea behind objective countertransference is that the therapist who is able to tolerate the transference feelings of the patient and can clearly differentiate his/her personal responses has a “truly objective countertransference,” to base subsequent interventions around (Winnicott, 1949, p. 70). For instance, Spotnitz (1999) suggests that after transference has developed and a Schizophrenic patient is able to appropriately verbalize

frustration-aggression, the therapist may intervene based on the feelings the patient has induced within the therapist him/herself.

Objective countertransference is thus based upon realistically induced emotions, or those that would be repeatedly induced interpersonally outside of the therapeutic setting (Spotnitz, 1999). Subjective countertransference, is then defined as “reactions attributable to insufficiently analyzed adjustment patterns in the therapist,” and is viewed as being embedded within distortions created by the memory process (Spotnitz, 1999, p. 229). Though the ideas of objective and subjective countertransference are commonly associated within the modern analytic tradition, the idea has also been supported by a leading interpersonal theorist, Donald Kiesler (1996, 2001). Yet, as Gelso and Hayes (2007) argue, if all emotional reactions can be described as countertransference reactions, then there would be no need to define the term at all. Thus, if the concept is to retain any empirical value, the totalistic view of countertransference must be dismissed as too broad (Gelso & Hayes, 2007).

Ferenczi (1919) was not the only early theorist to take up and extend the conceptualization of countertransference. In a 1926 paper entitled, “*Occult Processes Occurring During Psychoanalysis*,” Helene Deutsch suggested that the countertransference phenomenon was perhaps comprised of two elements; one connected to the analyst’s past and another connected to the patient’s past (Ernsberger, 1979). The task of the analyst therefore becomes a receiving of the patient’s associations, followed by a sifting through process within the analyst’s own unconscious, concluded by an intellectual processing of the gathered and sifted material (Deutsch, 1926). The idea behind this technical direction was the claim that in doing so the emotional aspects of the

patient's unconscious will first become an inner experience for the analyst and by then utilizing the analytic intellect, the therapist will come to recognize the emotional aspects as those belonging to the patient (Deutsch, 1926). This sort of direction can easily be compared to Freud's directive that the analyst should use his/her unconscious like a "receptive organ." Extending this line of thought, Deutsch (1926) argued that the processes she described were the quintessence of "intuition and intuitive empathy" and attempted to buttress this claim by pointing out that the psychic structure of the analyst is formed by the same general developmental processes as those of the patient (Ernsberger, 1979, p. 144). Deutsch (1926) further proposed that there were two other components of the countertransference process:

- 1) The analyst identifies with the patient's infantile ego (transference template)
- 2) As the patient transfers the attitudes and early feelings of early objects onto the analyst, the analyst identifies with those objects (Ernsberger, 1979, p. 144).

Deutsch (1926) explains:

However, countertransference is not limited to identification with certain portions of the patient's ego, which happen to be cathected in an infantile manner. He also entails the presence of certain other unconscious attitudes, which I would like to designate by the term "complementary attitude." We know that the patient tends to direct his ungratified libidinal wishes at his analyst, who, thus, becomes identified with the original objects of these wishes. This implies that the analyst is under the obligation of renouncing his real personality even in his own unconscious attitudes. So as to be able to identify himself with these imagines in a manner compatible with the transference fantasies of his patient. I call this process the "complementary attitude"...only a combination of both these identifications constitutes the essence of "unconscious countertransference. The utilization and goal directed mastery of this countertransference are some of the most important duties of the analyst The unconscious countertransference is not to be confused with however, with the analyst's gross, affective, conscious relationship to the therapist (pp. 137-138).

The aforementioned quote is important when understanding the evolution and conceptual progression of countertransference for a few reasons. First, Deutsch (1926) suggests that unconscious countertransference manifestations are not limited to the analyst's identifications with the respective patient's transference template, but must also include the "complementary attitude," which accompany such roles (Ernsberger, 1979, p. 144). For instance, using Ferenczi's (1919) previously discussed common transference template of the stern father, Deutsch (1926) theorizes that for true unconscious countertransference to occur the therapist must not only be placed in the role of stern father by the patient, but must also give up his/her authentic personality in order to play the role of the stern father. Additionally, what is so striking about Deutsch's (1926) advancement is that she openly advocates for both the utilization and "goal directed mastery," of such countertransference (pp. 137-138).

Deutsch's (1926) conceptualization of the countertransference is now referred to as the complementary view of countertransference and can be defined as "a complement or counterpart to the patient's transference or style of relating" (Gelso & Hayes, 2007 p. 9). What distinguishes this viewpoint from the totalistic definition is that despite its congruence with the totalistic conception that therapist reactions are unavoidable due to the patient's relational patterns and defensive structure, it stands apart by emphasizing the nuanced psychological dance that takes place over the course of therapy; patients consciously or unconsciously "pull" for certain reactions from the therapist and the therapist inevitably reacts to those pull creates subsequent reactions in the patient and so on (Gelso & Hayes, 2007).

As an extension of this idea, Racker (1957) describes the occurrence of complementary countertransference manifestations with the “the law of tallion” (p. 323). Simply put, the law states that positive transference is met with positive countertransference and negative transference is met with negative countertransference (Gelso & Hayes, 2007). While countertransference is therefore expected, it is not necessarily viewed as healthy, and navigating the resulting “countertransference neurosis,” should be seen as a critical aspect of therapy (Gelso & Hayes, 2007).

Within the Object Relational schools of psychoanalytic thought, the trigger for complementary countertransference reactions is often thought to be intrinsic within the defense commonly referred to as “projective identification” (Gelso & Hayes, 2007). Due to the difficult historical nature of this term, the author of this study believes it would be beneficial to briefly discuss the term before proceeding.

Projective Identification

To fully understand the complementary definition of countertransference, a few words on the development of the term projective identification might be helpful. Melanie Klein (1946/1952) was the first to coin the term “projective identification” to explain a process she saw in children, psychotic patients, and severely disorganized neurotic patients. Describing this phenomenon she writes, “When projection is mainly derived from the infant’s impulse to harm or control the mother, he feels her to be a persecutor. In psychotic disorders this identification of an object with the hated parts of the self contributes to the intensity of hatred directed against other people” (Klein, 1946/1952, pp. 300-301). In essence, Klein’s description of projective identification as a defense mechanism was little more than the classic definition of projection (Fink, 2007).

Racker (1968) extended the concept by defining it as something that occurs when the patient projects onto the analyst and then the analyst him/herself identifies with that projection. Described by Sandler (1987) as the second stage of the concept, Racker (1968) states that over the normal course of therapy, the analyst identifies with each part of the patient's personality; "id for id, ego for ego, superego for superego (p. 134)." He labels these to be "concordant identifications," which he believes to be "the basis of comprehension" (Racker, 1968, p. 135). If the therapist does not identify with the patient at every level, according to Racker (1968), he/she will fail to understand the patient. When an analyst fails to do so he/she may identify at the ego level "with the patient's internal objects for instance, with [his] superego---for instance with a patient's internalized punishing figure---especially when such "internal objects" are projected onto the analyst by the patient" (Racker, 1968, p. 135). Similar to Deutsch (1926), Racker (1968) labeled this as "complementary identification" but did not believe these identifications should be utilized but instead indicated a fundamental misunderstanding on the part of the analyst (p. 134).

As Sandler (1987) has put forward, stage three in the development of the concept of projective identification came with Wilfred Bion's (1962) extrapolation, which viewed the analyst as object or "container," into which the analysand can put whatever he/she wants into it (him/her). This differs from Racker's (1968) view that the analyst plays a complementary role by essentially making the analyst an object (container, receptacle) instead of a subject with an individual psyche that demands recognition (Fink, 2007). In essence, the therapist cannot therefore be held liable for feelings and therefore "countertransference," is really the patient's vicarious transference (Fink, 2007).

As Fink (2007) points out, while Klein (1957) discussed projective and introjective states as primitive ones seen in children, psychotic patients, and severely neurotic patients, she theorized that they generally disappear after the depressive position (1.5 years – 2 years) was successfully navigated (p. 49). Racker (1968), Bion (1962), and others (especially from the Object Relational analytic camp) extended this concept to include patients of all ages and diagnoses and thus further muddied the already problematic concept (Fink, 2007).

Despite capturing more of the interpersonal nature of countertransference than the classical or totalistic conceptualizations, the complementary view has been criticized because, as Gelso and Hayes (2007) highlight, interpersonal pulls by the patient, transference material and relational styles do not totally capture the therapist's internal world as a possible causal factor for countertransference manifestations. In other words, even though therapist issues are implied within with the definition, most of the focus remains focused on patient defenses and/or pathology. This is perhaps best seen in much of the third stage object relational ideals concerning projective identification where supposedly unconscious patient material is almost magically imparted within the analyst who then acts them out (Eagle, 2000; Fink, 2007). Thus, Gelso (2004) explains that the complementary view “tends to ignore what the therapist brings to the table and how the therapist, along with the patient, co-creates relationship dynamics” (p.234).

A fourth view of countertransference manifestations that overlaps considerably with the complementary view but lends itself to a deeper understanding of the therapist's contribution to the phenomenon is referred to as the relational perspective (Gelso, 2004). This perspective differs from the comple

mentary view by not assuming the inevitability of particular therapist reactions due to the patient's defensive structure and interpersonal patterns (Gelso & Hayes, 2007). It is often referred to as a "two-person psychology," and emphasizes co-construction (Gelso & Hayes, 2007, p. 12). In other words, the patient brings his/her individual psyche into the treatment and therapist brings his/her psyche into the treatment; the result of the therapeutic hour is a joint construction (Gelso & Hayes, 2007). Both individuals form the transference and countertransference and thus both phenomena are results of expected exchanges between patient and therapist dynamics (Gelso & Hayes, 2007). The problem that may arise from this perspective, however, is that by shifting focus from individual to joint creations, the reality that each person brings individual factors (some which are greatly distorted) can easily become an afterthought (Gelso & Hayes, 2007).

Taking the previously discussed definitions of countertransference into consideration, Gelso and Hayes (2007) have attempted to provide an integrative definition of countertransference as the "therapist's internal or external reactions that are shaped by the therapist's past or present emotional conflict and vulnerabilities" (p. 25). According to this definition, if a therapist reaction to a patient is to be considered as countertransferential, there must be a centrally involved unresolved issue or vulnerability within the therapist (Gelso & Hayes, 2007). In other words, for countertransference to occur, there is usually a "trigger" that occurs within the therapist and is often caused by a subtle or more overt behavior that takes place within the patient (Gelso & Hayes, 2007).

Points of Agreement

Despite difficulties concerning the definition and technical application of countertransference, there are some generalities that seem to be widely agreed upon within the psychotherapy community (Gelso & Hayes, 2007). As Gabbard (2001) has illustrated, analysts from diverse perspectives are in agreement that countertransference is a joint creation of the therapist and patient. Additionally, a patient will always attempt to make the therapist a transference object (see Gelso & Hayes, 2007). Thus, the therapist must work diligently to extricate him/herself from the transference-countertransference dynamic (Gabbard, 2001; Gelso & Hayes, 2007). Finally, according to Gabbard (2001) most of the analytic community now concedes that it is impossible for a therapist to conduct therapy as a neutral presence who works from a “blank screen” perspective (Gelso & Hayes, 2007).

Notwithstanding the intrinsic value of the behavioral observations in the development of psychoanalytic theory, like many analytic concepts, the importance of empirical support has taken a backseat for much of the concept’s history. As a result, an invaluable concept within psychotherapy research has thus become bogged down in diffuse theoretical jargon and conceptualizations. The classic method of analytic inquiry, however, is not the only reason that empiricism has stayed away from the realm of countertransference. Despite abundant theoretical examinations of the subject, countertransference as a construct has been difficult to comprehensively and accurately operationalize (Friedman & Gelso, 2000).

Empirical Research on Countertransference

Historically speaking, countertransference research has been difficult to conduct due to the tendency for therapists to be reluctant to disclose what their personal vulnerabilities or conflicts may be (Gelso & Hayes, 2002). However, despite this drawback, a comprehensive review of psychotherapy research literature has suggested that therapist factors explain a lion's share of the variance in the therapeutic outcome as opposed to the efficacy of any actual therapeutic discipline or technique (Wampold, 2001). Before continuing it might prove beneficial to the reader to briefly highlight the ways countertransference has been previously studied.

Until the mid-1990's countertransference reactions were predominantly examined through the use of analogue studies (Gelso, Fassinger, Gomez, & Latts, 1995; Hayes & Gelso, 1991, 1993; Latts & Gelso 1995; Peabody & Gelso, 1982; Robbins & Jolkovski, 1987; Yulis & Kiesler, 1968). Generally speaking, these studies employed traditional laboratory settings and simulated conditions consistent with situations found in real-time therapy sessions (Hayes, McCracken, McClanahan, Hill, Harp, & Carozzoni, 1998). Still, as Hayes et al. (1998) have called attention to, many of the previously mentioned analogue studies were extremely diverse in their foci and were thus problematic to assimilate into any meaningful unified theory of countertransference.

Quantitative field studies have also been a common way of measuring countertransference reactions (McIntyre & Shwartz, 1998). A limitation to this type of inquiry, however, is that they often fail to capture the authentic phenomenon of what is going on during countertransference reactions due to their lack of real-time observation. Additionally, similar to the previously stated issues inherent within quantitative

transference research, they often use self-reports that can be tremendously sensitive in nature due to issues commonly seen with countertransference reactions (sexual attraction, hatred towards patient, etc.). That is, even if therapists are aware of their countertransference reactions, they may be hesitant to report them or have difficulty doing so accurately.

Qualitative methods have also been used in hopes of integrating some of the results found using other methodologies into a larger theoretical framework (Hayes et al., 1998). Unfortunately, due to the lack of direction and focus exhibited during the collective analogue studies, qualitative methodologies have had to limit their respective scopes to try and augment the existing analytic findings (Baehr, 2004).

Stemming from the classical psychoanalytic methodology, case studies have also been used to learn more about countertransference manifestations (Rosenberger & Hayes, 2002). This being said, while case studies are certainly helpful in aiding the development of theoretical formulation and advancement, they are predisposed to become a limited methodology when considering possible patient variation (Rosenberger & Hayes, 2002).

One issue when discussing the empirical findings of countertransference research is that the origins of countertransference are multidimensional in nature, are “deeply embedded in the therapist’s psyche, and may reside somewhere outside of the therapist’s awareness” (Gelso & Hayes, 2007, p. 42). To circumvent this issue, some studies have attempted to isolate more transparent therapist variables, such as homophobia (Hayes & Gelso, 1993). Similar studies have examined fears of intimacy and longstanding grief in conjunction with termination issues (Boyer & Hoffman, 1993; Cruz & Hayes, 2006). Though perhaps limited in scope, these examinations of therapist variables have not

proved futile. Some therapist variables, such as gender-role conflicts, have been detected as accurate predictors of future countertransference manifestations (Fauth & Hayes, 2006; Hayes & Gelso, 1991; Peabody & Gelso, 1982; Rosenberger & Hayes, 2002; Yulis & Kiesler, 1968). Therapist comfort with various issues has also shown to be a positive indicator of countertransference manifestations. Therapists who report discomfort with anger have been shown to be more likely to have countertransference manifestations when presented with anger during a session (Bandura, Lipsher, & Miller, 1960; Sharkin & Gelso, 1993). In similar fashion, other studies have shown that therapist anxiety is also a reliable predictor of countertransference manifestations (Cohen, 1952; Hayes, Gelso, & Hummel, 2011).

Though helpful, much of the historical countertransference research has proven to be diffuse. Kiesler (2001) has therefore put forward the proposition that in order to empirically test and properly understand the phenomenon of countertransference, researchers must “take the time to assess the necessary behavioral baselines for therapists and their clients” (p. 1053). In agreement with Kiesler (2001), Gelso and Hayes (2001) have stated that the goal of countertransference research is to “discover nominal laws that might apply to more than single cases” (p. 114). The question that then comes to the forefront is: How do researchers discover information that is generalizable while examining individual therapist baselines that have not been historically reliable due to the sensitive nature of countertransference manifestations?

Using the CCRT as a Countertransference Measure

The usage of the CCRT as a possible countertransference measure becomes a logical extension of its previous uses when conceptualizing countertransference as a

therapist's activated transference template towards the patient. At minimum, the CCRT coding method could prove to be a helpful supplement to analogue research, qualitative research, and case studies by identifying possible countertransference origins. However, due to the nature of the CCRT, which extracts and codes narratives, many of the shortcomings exhibited in other methodologies (e.g., therapists' reluctance or inability to share vulnerabilities) are circumvented and therefore give the field of psychotherapy research much excitement regarding the possibilities the coding system has to offer. For instance, the CCRT could be utilized as a powerful training tool that could give therapists more insight into their own origins and triggers before entering a given session (Gelso & Hayes, 2007; Hayes, 2004). Another rich possibility for countertransference research utilizing the CCRT coding method rests in utilizing it to further examine therapist and patient interactions. If the CCRT coding method is indeed a valid countertransference coding method, it could prove to be an answer to Gelso and Hayes' (2007) call for future "research to examine the possible interactions between therapist variables and client interactions with these variables in hopes of limiting countertransference manifestations within session" (p. 126). Early examinations of the interactions between therapist variables and patient templates using the CCRT have shown promise including Wiseman and Tishby (2010) and Tishby and Vered (2011). These findings will be discussed in depth later in this chapter.

This being said, previous utilization of the CCRT as a countertransference measure is sparse at best. In an initial attempt, Bourke and Grenyer (2010) used the CCRT-LU coding method to examine how cognitive and emotional responses might fluctuate depending on a patient's diagnosis. Specifically, the study compared therapists'

reactions to patients suffering from Major Depressive Disorder (MDD) with those suffering from Borderline Personality Disorder (BPD).

Using a snowball sampling technique (Goodman, 1961), twenty therapists were recruited from health care facilities associated with a university health care system. Of the 20 therapist participants within the study, seventeen were female and three were male; 17 were doctoral-level and three were master's-level clinicians. Post-internship experience ranged from 2 to 14 years ($M = 6.5$ years, $SD = 3.28$). The mean age of the therapists was 34 years ($SD = 7.52$). The theoretical orientation break down of the therapist participants was 14 identified as practicing cognitive behavioral therapy (CBT) while six identified as interpersonal-dynamic (Bourke & Grenyer, 2010).

All therapist participants were asked to select four of their patients; two with a primary diagnosis of BPD and two with a primary diagnosis of MDD. Additionally, the cases that were to be discussed by therapist participants required them to have seen the respective patient for a minimum of eight sessions. Additionally, the therapeutic relationship had to be current or terminated within the previous twelve months to be included within the study

To obtain the therapist participants' individual CCRT template, the RAP interview instructions were read verbatim by the interviewer. The interviewer then instructed each therapist participant to answer in regard to the first patient with MDD, the second patient with MDD, the third patient with BPD, and the fourth patient with BPD. All narratives were then transcribed verbatim by an experienced transcriber (Grenyer, 2002). Two raters trained in the use of the CCRT-LU method independently coded the complete data set. Each interview narrative was considered an entire RE, with the focus

being on therapists' relations with a specified patient. To derive a consensus code for all CCRT components and valence scores, raters met and discussed disagreements in coding. Agreement was reached on all discrepant component rating without assistance from a third rater.

Results suggested that there were similarities in therapists' desire to be confident while conducting therapy (Bourke & Grenyer, 2010). Additionally, the therapists studied were consistent in their desire to support those patients suffering from MDD while assisting the development of independence in those patients diagnosed with BPD (Bourke & Grenyer, 2010). Due to the depth of the CCRT method, therapeutic perception was also something that was able to be commented on in the Bourke and Grenyer (2010) study. Patients with MDD were seen as providing consistently "harmonious" relational responses while those patients with BPD were seen as expressing discordant reactions (Bourke & Grenyer, 2010). Using the traditional coding of the CCRT to examine countertransference, these expressions by patients diagnosed with MDD and BPD would be coded as ROs or Responses from Other(s). Also, the most common response towards patients was one of support, which as Bourke and Grenyer (2010) have suggested, may be due to the fact that therapists initially advance relational empathy towards patients regardless of therapeutic diagnosis. Traditional CCRT coding adapted to look at countertransference would code this expression as Responses of Self or RSs.

Tishby, Wiseman, and Vered (2010) also attempted to examine countertransference with the CCRT method in therapist-client dyads. Participants consisted of two therapists and two patients who were monitored across three time points in a year-long psychodynamic psychotherapy. The mean age of the therapists was 29.5

years and the mean experience conducting therapy was 2.75 years. Utilizing Hayes' (2004) operational model of countertransference, which identifies origins, triggers, manifestations, effects, and management, Tishby et al. (2010) attempted to link the CCRT, a means of studying the origins of countertransference and effects on process, with manifestations that occur during therapeutic hour. This was done by examining the apparent activation of the CCRT in conjunction with documented changes in working alliance, post-session questionnaires, and OQ-45 scores). Countertransference manifestations included the following CCRT components: identification with the parent (RO), "repair" of the parent (RO), react to patient as parent (client RO), and distancing/withdrawal in response to countertransference content (RS). Results indicated that therapist CCRTs with parents may sometimes distort their perceptions of their clients, and influence their choice of interventions whenever countertransference is triggered during the therapeutic hour (Tishby & Wiseman (2014).

Wiseman and Tishby (2010) used the CCRT in conjunction with attachment theory in hopes of better understanding the interplay between interpersonal patterns, working alliance, and therapeutic outcome. Utilizing session material of 60 therapeutic dyads, the study examined the individual characteristic patterns that therapists and patients bring to the relationship and how these patterns interact with one another during different phases of therapy. Results indicated that the specific interplay between the CCRTs of therapists and patients play out according to the specific dyad's dynamics. For example, the deactivation of a specific therapist's attachment system was viewed as related to the CCRT themes of distancing and ambivalence while hyperactivation of CCRT themes

present within a specific therapist was viewed as a wish for closeness and seeing the other as distant.

Tishby and Vered (2011) also utilized the CCRT coding method to examine the countertransference manifestations of 12 female social workers who conducted psychodynamic therapy. Analogous to the Tishby, Wiseman, and Vered (2010) study, Tishby and Vered (2011) extracted the CCRT of the participating therapists by examining narratives regarding his/her parents. Countertransference manifestations within session indicated that there was a high repetition of parental themes in narratives about patients for all three components of the CCRT (Wish, Response from Other, and Response of Self). Additionally, more validation was given to the findings of Tishby, et al. study (2010) by a qualitative analysis which included repeating the actions of the parent, repairing the actions of the parent, identification with the patient, and distancing (Tishby & Vered, 2011).

Thus, while the CCRT has been hitherto used successfully to denote countertransference origins and manifestations within the therapeutic setting, especially when looking at how therapist attachment or patients' with various diagnoses may activate or "trigger" countertransference reactions, research has been limited. For instance, none of the previously mentioned studies held validating the CCRT as a measure of countertransference as their primary focus. Additionally, none of the previously mentioned CCRT countertransference studies have been conducted in the United States, which brings questions of cultural validity to the forefront as well. Therefore, more overall research is needed to justify using the CCRT method as a valid countertransference coding method. However, as Tishby and Vered (2011) point out, if

the CCRT continues to show the aforementioned depth of results, the CCRT may be a response to Gelso and Hayes' (2007) call for the field of psychotherapy research to unearth "sophisticated ways of capturing the often unconscious roots of countertransference reactions" (p. 127).

Rationale for the Current Research

The current study has been designed in hopes of validating the use of Luborsky's Core Conflictual Relationship Theme (CCRT) coding method, which has previously been used as a method for extracting a patient's transference template, as a way to identify and extract a therapist's respective countertransference template. Additionally, this study seeks to not only identify a therapist's countertransference template, but also examine how his/her template may or may not be activated throughout the course of therapy.

Broad Research Questions

While contemplating the current study, three central research questions emerged. First, can the CCRT, a coding system that has been historically used to identify a patient's core conflictual relationship theme consisting of his/her most frequent wishes, responses from others, and responses of self be used to successfully identify a therapist's countertransference core conflictual relationship theme? Second, once extracted will a therapist's respective CCRT become evident throughout the course of therapy? Finally, in regards to Hayes and Gelso's integrative definition of countertransference, will a therapist's CCRT only be activated with certain types of patients who provide the necessary activating "hooks" or "triggers"?

Chapter 3

Method

Research Design

Due to the lack of research concerning the CCRT's validity as a countertransference coding method, the author of this study chose to undertake an in-depth case study of one therapist's experience within the therapeutic setting with multiple clients. By taking a more exploratory point of entry into the utilization of the CCRT as a countertransference coding method, the author hoped to capture some of the richer relational complexities that have hitherto evaded countertransference research methods (Gelso & Hayes, 2007).

Participants/Recruitment

Participating Therapist

This study was conducted at a large, northeastern university counseling center. Upon receiving approval from the university's institutional review board, two separate invitational emails were sent out over the course of one month (one every two weeks) to counselors/therapists who worked at the above-mentioned university counseling center and had a M.A. or M.S. in a counseling-related field. The emails asked for the cooperation of therapists who had available time and were interested in aiding the advancement of psychotherapy research (Appendix A). Additionally, a stipend of \$100.00 was offered as an incentive for therapist participation.

From two therapists who responded to the invitation emails, a single therapist was selected who met the following additional criteria: she was able to get clearance from her supervisor, her clients were willing to participate in the study, and she had available time

to meet with research team members to complete initial consent-related paperwork, go over clinical directions, and complete a Relationship Anecdote Paradigm (RAP) interview.

The selected therapist then met with the author of this study to complete initial consent-related paperwork. The therapist was not given specific information regarding the nature of the study other than that it sought to examine the therapy process. Approximately one week after the selected therapist signed the informed consent to participate in the study, the principal investigator administered the Relationship Anecdote Paradigm (RAP) interview (see below).

The participating therapist was a 30-year old, European American, heterosexual female who was enrolled in a doctoral program in psychology. She had more than five years of experience working in a university counseling center. Additionally, the participating therapist was under weekly individual and group supervision as a requisite for the completion of her advanced degree.

An attempt was made to gather consent from as many of the therapist's clients as possible. The reason for this was twofold: 1) it allowed the research team to diversify the types of clients (e.g., demographics, presenting issues, diagnosis) that would be studied in relation to the therapist's countertransference; and 2) it served as a protective buffer against those cases that were unable to have at minimum three therapy sessions before termination.

The therapist was asked to inform multiple clients on her caseload via a brief email that she was participating in a psychotherapy research project that was examining the nature of the therapeutic process. The therapist was instructed to inform clients that

they could earn up to \$75.00 if they participated in the study, and if they were interested they should contact the principal investigator directly via email.

Upon contacting the principal investigator, interested clients were informed that if they should choose to participate in the study, up to the first five of their therapy sessions would be audiotaped and transcribed. All clients were also made aware that all identifying information would be kept confidential, and all transcriptions would use de-identified data. Finally, all interested clients were informed that upon consent, no additional time or information would be required for their participation within the study. If the client verbally agreed to the aforementioned terms, he/she was referred to, and met by, the study's research assistant to sign consent forms and provide demographic information. The research assistant also explained the following payment format: for participating in three sessions, the client would receive \$35.00; for participating in four sessions, he/she would receive \$50.00, and for participating in five sessions, he/she would receive \$75.00.

Participating Clients

Client #1: Client #1 was an 18-year old, heterosexual, European-American female who was studying music and had recently experienced a concussion while participating in a sporting event. While the concussion and associated symptoms constituted the client's primary presenting problem, the client also reported current physical abuse and historical sexual abuse by her biological father.

Client #2: Client #2 was a 19-year old, heterosexual, European-American male who was studying engineering and was struggling with a recently ended heterosexual relationship. The client was contemplating leaving college due to a poor class attendance record.

Client #3: Client #3 was a 24-year old, heterosexual, European-American female who was studying graduate level psychology. The client reported that her on-again/off-again boyfriend was physically abusing her.

Participating Coders

Coders were selected in the following way: First, the principal investigator collected names of top students from the instructor of a master's level "Theories of Psychotherapy" class. Top students were defined as those who participated in class and scored the highest grades on the first exam of the semester. Next, the principal investigator sent an email to these students regarding the nature of the study and inviting them to interview for the position of coder should they be interested in the study or gaining research experience. Each student who was interested was interviewed separately. Criteria for selection included the following:

- 1) The student was enrolled in a graduate program in a psychology-related field.
- 2) The student had prior knowledge of psychotherapy processes, especially those commonly that take place in psychodynamic therapy (this theory had been covered in the class from which students were selected).
- 3) The student had a desire to learn more about transference and countertransference from both a theoretical and clinical perspective.
- 4) The student was taking counseling-related classes as a requisite for the completion of his/her advanced degree.

*Coder Demographics**RE Raters, Group #1*

RE Rater #1 was a 28-year old, European-American female with an undergraduate degree in human development and family studies. The rater was pursuing a Master's of Education degree in Counselor Education. The rater had two years of experience working in partial hospitalization programs and one year of work experience in a residential treatment facility.

RE Rater #2 was a 24-year old, European-American male with an undergraduate degree in psychology with a minor in criminal justice. The rater was pursuing a Master's of Education degree in Counselor Education with an emphasis in school counseling. The rater had approximately 15 months of clinical experience working as a Therapeutic Staff Support employee.

RE Rater #3 was a 24-year old, European-American female with an undergraduate degree in psychology. The rater was pursuing a Master's of Education degree in Counselor Education and had .5 years of clinical experience.

RE Raters Group #2

RE Rater #1 was a 22-year old, European-American female who held an undergraduate degree in French and was finishing her Master's of Education degree in College Student Affairs. The rater had .5 years of clinical experience.

RE Rater #2 was a 23-year old, European American female who held an undergraduate degree in human development and sociology. The rater had 0 years of previous clinical experience and was finishing her Master's of Science in Higher Education and College Student Affairs.

RE Rater #3 was a 37-year old, European-American female who held an undergraduate degree in student affairs and was finishing her Master's of Education in Counselor Education. The rater had 0 years of previous clinical experience, but had worked as a college admission's counselor for 9 years.

CCRT Component Coders, Group #1

CCRT Component Coder #1 was a 24-year old, European-American female with an undergraduate degree in psychology and a minor in biology. The coder was pursuing a Master's of Education degree in Counselor Education and had .5 years of clinical experience.

CCRT Component Coder #2 was a 24-year old, European-American female with an undergraduate degree in human development and family studies. The coder was pursuing a Master's of Education degree in Counselor Education with an emphasis in secondary school counseling. She had no clinical experience.

CCRT Component Coders, Group #2

CCRT Component Coder #1 was a 23-year old, European-American female who held an undergraduate degree in agricultural business. The coder had 0 years of clinical experience and was working on her Master's of Science in Higher Education with an emphasis in college student affairs.

CCRT Component Coder #2 was a 34-year old, European-American female who held an undergraduate degree in communication arts and sciences with a minor in women's studies. The coder was finishing her Master's of Education in Counselor Education. The coder had .5 years of clinical experience and 9 years of academic advising experience.

Measures

Therapist Appraisal Questionnaire (TAQ)

The 20-item Therapist Appraisal Questionnaire (TAQ) is a self-report measure of emotions experienced by therapists during a session. The TAQ was originally developed via factor analysis by Cooley and Klinger (1989) within the field of social psychology. In hopes of examining the countertransference phenomenon, Fauth, Hayes, Park, and Friedman (1999) extended the measure by four items. The TAQ has three subscales: Threat (e.g., worried, fearful, anxious), Harm (e.g., angry, guilty, disgusted), and Challenge (e.g., hopeful, pleased, energetic). Emotions are rated by therapists on a 5-point Likert scale immediately after session. By examining extreme emotional reactions, the TAQ can be used as a measure of affective countertransference (Fauth & Hayes, 2006). Utilizing Kiesler's (2001) idea that countertransference represents atypical therapist reactions, affective countertransference reactions were operationalized as occurring when a subscale mean on a given administration of the TAQ was two or more standard deviations away from that subscale mean across all administrations of the TAQ.

Core Conflictual Relationship Theme (CCRT)

The Core Conflictual Relationship Theme (CCRT) coding method is a quantitative method used to isolate, extract, and identify core conflictual patterns commonly displayed within relational narratives and is congruent with Freud's 1912 description of transference (Luborsky, 1998a). The method itself can be divided into two distinct phases: a) the isolation and extraction of relationship episodes from transcribed psychotherapy sessions and b) the evaluation of those relationship episodes for evidence of the three components that make up the CCRT (i.e., wishes, response to other, and

response to self). While an individual's CCRT was historically formulated from material found within transcribed psychotherapy sessions, Luborsky (1998c) developed the Relationship Anecdotes Paradigm (RAP) interview in hopes of formulating CCRT's outside of the therapeutic setting, or if psychotherapy sessions were not available for scoring.

The RAP interview has been identified as a way to gather a significant amount of data on an individual's central relationship pattern (Luborsky, 1998b). Due to the sensitive nature of this study, the author believed that the non-threatening RAP interview, which is based on a relatively natural format, would be the quickest and most efficacious way of illuminating potential countertransference struggles (Luborsky, 1998b). In a study by Barber, Luborsky, Crits-Christoph, and Diguier (1995) which compared the reliability of spontaneous narratives within psychotherapy sessions with those produced in RAP interviews, it was found that the percentage of agreement between two raters on the standard category clusters (described below) in RAP interviews was 84% for wishes, 100% for responses from others and 87% for responses from self. The corresponding weighted kappas were .68, .60, and .65, respectively, which reflected fairly strong agreement between raters (Landis & Koch, 1977; Luborsky, 1998b).

RAP Interview Procedure

The author of this study met with the selected therapist and conducted a RAP interview. In accordance with the RAP interview instructions suggested by Luborsky (1998c), the following directions were given:

Please tell me some incidents or events, each involving yourself in relation to another person. Each one should be a *specific* incident. Some should be current

and some old incidents. For each one tell (1) when it occurred, (2) who was the other person it was with, (3) some of what the other person said or did and you said or did, (4) what happened at the end, and (5) when the event in the narrative happened. The other person might be anyone --- your father, mother, brothers and sisters, or other relatives, friends or people you work with. It just has to be about a specific event that was personally important or a problem to you in some way.

Tell at least ten of these incidents. Spend about three but no more than five minutes in telling each one. I will let you know when you come near to the end of five minutes. This is a way to tell about your relationships. Make yourself comfortable and engage in this RAP session as you would with someone you want to get to know you (p.110).

The RAP interview was recorded and transcribed with additional information supplied at the beginning of the transcript including date, initials of therapist-participant, and the interviewer's name (Luborsky, 1998b). The participating therapist was free to tell any incident she chose, but was asked to elaborate if the narratives were too short or lacked detail (Luborsky, 1998b). Additionally, the therapist was asked to identify when these particular incidents happened (e.g., within the last few days, within the past three years, more than three years ago) for the purpose of scoring (Luborsky, 1998b).

Phase A of CCRT: Demarcation of Relationship Episodes

Phase A of the CCRT coding method involves locating and identifying relationship episodes or "REs." During this phase, two relationship episode raters individually read over an entire transcript. Upon reading the transcript, the first group of raters identified, isolated, and examined relationship episodes or "RE's" within the text.

In each RE a central “other” is identified. If the therapist identified multiple people during a particular narrative, it was not considered problematic unless there was not an identifiable “main other” (Luborsky, 1998b). REs were marked within a transcript by a vertical line on the left margin and served as the basis for making inferences regarding CCRT components (Luborsky, 1998b).

Once REs were identified, RE coders rated on a scale from 1.0 to 5.0 (least to most detailed) how complete a particular relationship episode was (Luborsky, 1998b). A score of 1.0 would be the least complete RE while a score of 5.0 would denote the most detailed RE. A rating of 1.0 by a RE rater would mean there are no CCRT components. A rating of 1.5 would denote a fairly imprecise CCRT component. A 2.0 rating would indicate multiple ambiguous components. A 2.5 rating demands that there is enough information to score a wish, response from other, and response of self. A rating beyond 2.5 depended on how much elaboration and detail the therapist gave regarding the three CCRT components. The cut-off for scoring wishes, responses from others, and responses from self is a mean completeness score of 2.5 for any given RE. Examples of RE completeness criteria are provided in Appendix C.

Additionally, episodes are delineated by the time period they occur: RE raters should approximate the age of the participant at the time of the RE event within the narrative, as well as the approximate date of the event. Current REs that occur within the session or a few days before the session are demarcated as (REc), or relationship episode current, within the transcript. Recent RE’s that have occurred within the last three years are listed as (REr) and every other RE is considered a past relationship episode and is noted as (REp) (Luborsky & Crits-Christoph, 1998). A minimum of ten relationship

episodes is required to move into Phase B of the scoring. Finally, all disagreements between the initial two RE raters are handled by a third and final RE rater who looks at the previous two RE ratings and makes a final decision on what to send to Phase B scoring.

Phase B: Identification and Extraction of CCRT components

Phase B, the more involved stage of the coding, included the extraction of the actual CCRT by examining each respective RE for the following CCRT components: W's (wishes, needs, or intentions), RO's (responses from other), and RS's (responses of self) (Luborsky, 1998b). Within the standard scoring system there are 35 possible wishes, 30 possible responses from other, and 31 possible responses of self. The components have been further clustered into three groups of eight: 8 Ws, 8 ROs, and 8 RSs (as seen in Appendix B) in hopes of refining the coding method. Also, each type of response is defined as mostly positive (P) or mostly negative (N) (Luborsky, 1998b).

To begin Phase B of the CCRT coding method, pairs of CCRT coders individually read, reread, and scored the demarcated REs from either the RAP interview or from individual therapy sessions (Luborsky, 1998). Within the transcript, each coder marked the excerpts that were scored as CCRT components. Each excerpt is referred to as a single thought unit (Benjamin, 1986). An example of a thought unit within a transcript might read: "She was continually emasculating in her tone," which might later be scored as negative response from other (NRO), "critical of me."

Most frequently, individual thought units would be given a single score for one CCRT component. However, on occasion two components may be scored from a single thought unit (Luborsky, 1998). To do this effectively, the individual coder chooses the

most appropriate standard category, as well as the second most appropriate standard category for each CCRT component (W, RO, RS). From the standard categories, the individual component coders narrow their description of observation by choosing a primary and secondary component. Caution is taken when considering both the explicit and inferred thought units. All scores are then taken from the transcript and then transferred to a scoring sheet. Scored components are summed for frequency of occurrence. And the most frequently scored components within the transcript formulate the CCRT expression. Coders are then instructed to repeat the abovementioned process as a review that might improve the assessment by examining a particular component with the newfound insight of the initial CCRT formulation. Thus, the CCRT is expressed by highlighting the most common or recurrent Ws, ROs, and RSs across the given narratives (Luborsky & Crits-Christoph, 1998).

Within the standard scoring system there are 35 wishes, 30 responses from others, and 31 responses of self. Each component can be further clustered into one of 8 clusters as seen in Appendix B (8 Ws, 8 ROs, & 8 RSs). Each CCRT coder is independent and blind of the other raters' responses (Luborsky & Crits-Christoph, 1998). After each coder scores an entire transcript, the clusters and components are calculated with those of the other coder. The traditional agreement procedure used in the CCRT is that of Cohen's (1968) weighted kappa. According to Diguier, Barber, and Luborsky (1993) the interrater reliability coefficient should range from .61 to .70. For more information regarding statistical agreement, consult the statistical analysis portion of this chapter.

Wishes

Within the traditional CCRT coding system, there are 35 categories of wishes. For a complete list of the wishes, please see Appendix B. Barber et al. (1998) compacted the individual categories into eight wish “clusters.” The eight clusters of wishes are as follows: 1) to assert self and be independent 2) to oppose, hurt and control others 3) to be controlled, hurt and not responsible 4) to be distant and avoid conflicts 5) to be close and accepting 6) to be loved and understood 7) to feel good and comfortable 8) to achieve and help others. Wishes or W’s stand for needs, or inferences are perhaps the most difficult CCRT component to identify due to the two levels of inference: explicit and moderately inferable (Luborsky, 1998b). An explicit wish is often directly stated by using words such as “wish,” “want,” “desire,” “thirst,” etc. while a wish with a moderate level of inference, though recognizable, are far less direct (Luborsky, 1998b). An example of a wish with moderate inference might be, “I always believed in what he said.” The standard category wish component in the aforementioned statement is “to have trust.” Wishes with moderate inference are presented within the CCRT scoring system by placing parentheses around the component (W). (Ws) are especially essential to the current study because they are more likely used throughout the RAP interview than direct Ws (Luborsky, 1998).

Responses from Other(s)

Within the traditional CCRT coding system, there are 30 responses from other(s). For a complete list of the responses from other, please see Appendix B. Barber et al. (1998) compacted the individual categories into 8 response from other(s) “clusters.” The eight clusters of response from other(s) are as follows: 1) strong 2) controlling 3) upset 4)

bad 5) rejecting and opposing 6) helpful 7) likes me 8) understanding. A response from other, the second component within the CCRT coding method, is explicitly in relation to the main “other.” ROs are commonly consequences of an explicit or inferred wish.

Additionally, ROs are further coded for positive or negative valence. Additional markers are used to denote extremes (PP, NN). An example of a PRO would be “He gave me a hug and told me loved me.” A NRO would be: “What a cold jerk”

Responses of Self

Within the traditional CCRT coding system, there are 31 responses of self. For a complete list of responses of self, please see Appendix B. Barber et al. (1998) compacted the individual categories into eight responses of self “clusters.” The eight clusters of responses of self are as follows: 1) helpful 2) unreceptive 3) respected and accepted 4) oppose and hurt others 5) self-controlled and self-confident 6) helpless 7) disappointed and depressed 8) anxious and ashamed. A response of self is a client’s symptom as they are explained within a relationship episode. Like ROs, RSs are often consequents of Ws. Also, like ROs, RSs are further coded for positive and negative valence. Additional markers are used to signify extremes (PP, NN). A positive RS, or PRS would be: “I walked away feeling like a million bucks.” A negative RS or NRS might be: “I can’t stand them.” One other note about ROs: they are only scored as ROs if the “other” actually performed the given response. Otherwise, they are known as RO expected. An example of this differentiation might read as follows: “She never showed up.” – NRO: rejection. As opposed to, “I never even called because I knew she would never show up.” –NRO expected: rejection

Training Procedures for RE Raters and CCRT Coders

Two separate coding classes were formed approximately one year apart. The same protocol was used for both coding classes so that, if needed, coders from either class could be used interchangeably. Additionally, each student was taught the entire CCRT procedure and was only placed into a specific coding group after learning to adequately perform all functions of the coding process. To facilitate the learning and subsequent execution of the coding procedure, each training class was divided into five sessions. The first two sessions were devoted to the concepts of transference and countertransference. To assist this discussion, each student was given the following papers to read: Freud's (1904) *Observations on Transference Love*, Freud's (1912/1958a) *Dynamics of Transference*, and a chapter from Norcross' (2011) *Psychotherapy Relationships that Work* (2nd edition) entitled, *The Management of Countertransference* by Gelso and Hayes (2011). Each session was approximately two hours long and took place in a group-discussion format.

The subsequent two sessions were also two hours long but discussed the CCRT method in detail. As suggested by Luborsky (1998), each student was given chapters two and five in his book entitled, *Understanding Transference: The Core Conflictual Relationship Theme Method*. These chapters were given because they explain the coding method in detail and provide detailed case examples. During these training sessions, the principal investigator fielded all questions regarding the assigned CCRT readings.

After the initial, four two-hour sessions, a fifth and final five-hour training session was arranged and conducted by the author of this study. During the five-hour training session, the famous Gloria tape transcriptions were handed out to each student. Ensuing

training led to the coding of both relationship episodes and components within the transcripts. For group training purposes, portions of the Carl Rogers and Fritz Perls sessions were transcribed line-by-line by the coding teams. Each portion of coding was followed by group feedback in hopes of aiding future reliability as suggested by Luborsky (1998) regarding CCRT training procedures. Finally, in addition to the Rogers and Perls' cases, the students were asked to take the Albert Ellis section of the transcript home to transcribe by themselves. Upon completion, the author of the study collected and examined the coded transcripts from each student to ensure quality and provide feedback. This training procedure was also in accordance with Luborsky's (1998) premise that the "experience of scoring several practice cases is important for improving skill" (p. 36).

Procedures

After the selected therapist was given a RAP interview, a first set of RE raters isolated and scored relationship episodes for completeness. A second set of CCRT component coders then demarcated the relationship episodes for CCRT components in the context of the RAP interview transcript. The most pervasive CCRT components were extracted from individual thought units within relationship episodes and were then used to calculate the participant-therapist's preliminary CCRT. CCRT component coders were then asked to review the scores to see whether anything had been omitted or needed revision before moving to the next phase of the study.

After the therapist's individual CCRT was extracted, three of the therapist's clients were selected based on demographic information, diagnostic information, and available sessions. Upon consent, the clients' 50-minute therapy sessions were recorded

and transcribed. Though this study aimed to have 15 audio-recorded sessions (5 from each client) one session was not recorded by the therapist. Upon completion of each therapy session, the participating therapist filled out a TAQ measure. TAQs were filled out following 12 sessions.

A group of 3 RE raters examined the 14 transcribed therapy sessions and demarcated therapist talking turns that could be rated as relationship episodes. As was completed during the RAP interview, CCRT component coders demarcated the 14 transcribed therapy sessions for respective CCRT components. Comparisons were made between the therapist's CCRT derived from the RAP interview and from the 14 sessions with three clients.

Statistical Analysis

The CCRT scoring system is made up of 35 categories of wishes, 30 responses from others, and 31 responses of self. Utilizing cluster analysis, Barber et al. (1998) compacted the individual categories into eight "clusters." To determine reliability in the categorization of wishes, responses from other, and responses to self, weighted Cohen's kappas were calculated during Phase B of both the RAP interview and psychotherapy sessions by examining the observational responses each group (2 RAP CCRT component coders, 2 therapy session CCRT component coders) of CCRT component coders made. As previously stated by Cohen (1968), kappa is defined as the proportion of agreement after chance is removed. However, it is often necessary to weight agreement in order to make it more precise. The justification for this postulate is that certain disagreements are less critical than others, and should be given a value between 1 (perfect agreement) and 0 (perfect disagreement) in hopes of giving a more valid estimation of reliability

(Luborsky, 1998). In accordance with Luborsky's suggested agreement procedure, the procedural weights for this study were as follows: a) agreement between CCRT component coder #1 and CCRT component coder #2 regarding the best fitting CCRT cluster for each component was given a 1.0; b) agreement on a match between the best fitting CCRT component by CCRT component coder #1 and the next best fitting category of CCRT component coder #2 was given a weight of .66; c) when both CCRT component coders agreed on the next best fitting category a .33 weighted kappa was assigned and d) when there was no match between categories, a 0 score was recorded (Waldinger, Seidman, Gerber, Liem, Allen & Hauser, 2003). Landis and Koch (1970) provided useful standard ranges for evaluating the degree of agreement using kappa: 0 to .39 = poor; .40 to .74 = fair to good; .75 to 1.00 = excellent. For this study, the weighted kappas for cluster agreement for the RAP interview CCRT component coders was as follows: $W_s = .67$, $ROs = .51$, and $RSs = .57$. The weighted kappa cluster agreement for the therapy session CCRT component coders was as follows: $W_s = .78$, $ROs = .33$, and $RSs = .78$. The extremely low kappa for ROs was likely due to the limited number of coded ROs (3). The weighted kappa cluster agreement for the 16 incomplete relationship episodes was .75.

Correspondence Between CCRTs from RAPs With CCRTs from Sessions

To examine correspondence between the CCRTs from therapist RAPs with those witnessed in session, Barber et al.'s (1995) method was used. Barber et al. (1995) also compared core conflictual relationship themes derived from pre-treatment RAP interviews with those derived from early psychotherapy sessions. To compare the two CCRTs, ratings were first combined from each team of CCRT component coders. When

there was agreement between the two raters who scored the RAPs, the categories that were agreed on were used in the comparison with the CCRT from sessions. Conversely, if there was agreement between the two coders who scored the psychotherapy sessions, the categories that were agreed upon would be compared to those found within the RAP interview.

Chapter 4

Results

Preliminary Analysis

Countertransference Manifestations

Indications of countertransference manifestations were measured in two ways. First, the Therapist Appraisal Questionnaires (TAQs) were examined for self-reported indicators of atypical feelings and/or possible countertransference manifestations. To do this effectively, a baseline was created by finding the average score of each of the TAQ's three scales: Challenge, Threat, and Harm, for each of the three patients and then the group of three patients, across 15 sessions, as a whole. In accordance with Kiesler's (2001) hypothesis that countertransference behavior is "atypical" in nature, endorsement of subscales that were two standard deviations from the baseline (mean) were considered atypical and therefore noteworthy. None of the subscales were atypical (two or more standard deviations away from the mean) for the individual patient sessions or across sessions. Thus, a decision was made to examine less extreme subscale scores that were one or more standard deviations from their respective means. Using this criterion, it was determined that 11 subscales were one or more standard deviations from their respective means during individual therapy sessions, and 12 subscales were one or more standard deviations from their respective mean across sessions. With patient #1 there were subscale scores one or more standard deviation away from the mean during sessions #1.2 (Threat), #1.3 (Harm, Challenge), and session #1.5 (Harm). For patient #2 there were subscales one or more standard deviations away from the

mean during session #2.3 (Harm), session #2.4 (Threat), and session #2.5 (Challenge). For patient #3 there were subscales one or more standard deviations away from the mean during session #3.2 (Threat, Challenge) and session #3.5 (Threat, Harm). Across sessions, session #1.3 had three subscales (Threat, Harm, Challenge) one or more standard deviations away from the mean. Session #1.4 had 2 subscales (Threat, Harm) one or more standard deviations from the mean. Session #2.1 had one subscale (Challenge) one or more standard deviation away from the mean. Session #2.3 had two subscales (Threat, Challenge) one or more standard deviation away from the mean. Session #2.4 also had two subscales (Harm, Challenge) one or more standard deviation away from the mean. Sessions #2.5 had one subscale (Harm) one or more standard deviation away from the mean. Session #3.1 had one subscale (Harm) one or more standard deviation from the mean. For a more complete analysis of the Challenge, Threat, and Harm TAQ subscales of the individual patients, and the group as a whole, see tables 4.2 through 4.5.

Therapist CCRT

Within the RAP interview transcript, the RE raters deemed 12 of 14 (86%) relationship episodes to have over a 2.5 on the CCRT completeness scale and therefore were able to be coded for CCRT components in the traditional manner. The participating therapist's CCRT was as follows. The most pervasive wish (W) cluster was cluster #6, "To be loved and understood," with the central wish component being "to be respected," which was identified 10 times by the component coders. A secondary wish component was "to be accepted" and was

identified 8 separate times throughout the transcript. The most commonly coded response from other(s) (ROs) cluster was cluster #5, “rejecting and opposing.” The most common RO components were “are not understanding” and “don’t respect me” with six identifications each. The most commonly coded response of self (RSs) had a negative valence and came from cluster #7, “disappointed and depressed.” The most commonly coded RS components were “disappointed” with ten separate identifications and “helpless,” with nine separate identifications. Simply put, the therapist’s CCRT was: W - “To be loved and understood,” RO - “Rejecting and Opposing” and RS - “Disappointed and Depressed.” The weighted kappas for cluster agreement for the RAP interview CCRT component coders was as follows: Ws = .67, ROs = .51, and RSs = .57. For a full summary of CCRT component coding within the RAP interview, please see Table 4.1.

Question One

Of the 14 relationship episodes given by the participating therapist, 12 (86%) were rated as 2.5 or above in completeness. For a better understanding of the demarcation between a complete and incomplete relationship episode, please consult chapter three and/or Appendix C. Utilizing Gelso and Hayes’ (2007) integrative definition of countertransference as the “therapist’s internal or external reactions that are shaped by the therapist’s past or present emotional conflict and vulnerabilities,” there is sufficient reason to believe that the selected therapist’s Core Conflictual Relationship Theme was indeed extracted with demonstrated agreement among CCRT component judges (p.25). However, while this method has demonstrated validity and reliability regarding the extraction of an individual’s

transference template, it seemed to lack precision when compared to the expressions found within the therapeutic settings. Therefore, evidence suggests that an unmodified CCRT coding system cannot be used to capture a therapist's countertransference template. For further discussion, please consult chapter five.

Question Two

Once extracted, it was then questioned whether or not a therapist's CCRT would become evident throughout the course of therapy as demonstrated by the non-modified coding presented in Luborsky's (1998) standard CCRT coding method. Results failed to support this hypothesis. Of the 14 transcribed sessions, 0 complete relationship episodes (rated by coders over 2.5 on completion scale) were found. However, due to the nature of this study, which was in many ways exploratory, it was deemed appropriate to examine the incomplete relationship episodes (below 2.5 on the completeness scale) to determine whether or not the CCRT coding method could possibly be used as a countertransference coding method with modifications, or if the CCRT might be used to document specific countertransference origins (unresolved wishes, etc.). For further detail regarding this matter please see the additional analyses section of this chapter.

Question Three

Finally, again using Gelso and Hayes' (2007) integrative definition of countertransference, it was questioned whether or not a therapist's respective CCRT would only be activated by certain types of patients who provided the necessary activating "hooks" A "hook" was operationalized by an unresolved conflictual issue stemming from the patient's past as identified by the CCRT component "wish" (W)

category. This question was contingent upon the answering of question two. Thus, the answer to this question did not result in a confirmation or refutation, as it was found that during this project activating “hooks” did not manifest as an exact exhibition of the participating therapist’s CCRT. However, it may be the case that the patient’s CCRT was modified to become more socially acceptable. For further details regarding this matter, please consult chapter five.

Additionally, it is notable that during one particular session (patient #1, session #3) there was high endorsement on all three TAQ subscales (Threat, Harm, Challenge) when examined across all sessions (12 sessions).

Upon filling out the TAQ, the therapist endorsed atypical feelings (2.0 standard deviations away from the mean of each item) on the angry (3), fearful (4), and energetic (0) TAQ single items. However, the TAQ subscales: Challenge, Harm, and Threat showed no atypical elevations. This being said, though none of the TAQ scales showed elevations 2.0 standard deviations away from the mean, after examining some of the highly elevated single item, and elevated subscale scores of the TAQ, the author of this study deemed it necessary to examine elevated TAQ scores that were one standard deviation from the mean in hopes of finding some of the more nuanced manifestations of countertransference.

CCRT material was also present throughout the recorded sessions. Of the 16 incomplete relationship episodes documented throughout the 14 audio-recorded sessions, 5 (31%) were found in a single session (patient #1, session #3). Taken in conjunction with the elevated TAQ endorsements, this may be an indication countertransference manifestations were occurring during session #1.3, albeit in a

more nuanced manner than denoted by the traditional CCRT coding method. For more insight into possible manifestations, please see the additional analyses section of this chapter, as well as the discussion of results in chapter five.

Additional Analyses

Along with the TAQ, the CCRT coding method was employed in hopes of triangulating countertransference material. However, as stated previously, of the 14 audio-recorded therapy sessions 0 (0%) sessions were rated as complete enough (2.5 or above) to move to the CCRT component portion of the coding method. This being said, throughout the 14 audio-recorded sessions, 16 relationship episodes were demarcated and rated as incomplete (below 2.5 in completeness) by RE raters. Incomplete relationship episodes ranged from 1.0 to 2.0 on the CCRT completeness scale. Thus, the author of this study felt it efficacious to examine the incomplete relationship episodes for partial evidence of the therapist's CCRT. The thought behind this examination was that therapists rarely make self-disclosures that include all three components of the CCRT and therefore most therapists' expressions of CCRT material would be more nuanced than when a patient tells a narrative during the therapeutic hour. If so, even incomplete relationship episodes could provide insight into countertransference phenomena, specifically, countertransference origins. Another reason the author deemed it important to examine the study's incomplete relationship episodes was the hope that in doing so, future research aimed at molding the traditional CCRT into a more useful, modified countertransference coding method might also benefit.

In order to code the 16 incomplete relationship episodes, an additional set of two CCRT component coders who were not utilized during the first part of the study, were used to code the incomplete relationship episodes. They were not informed of their previous counterparts findings. Of the incomplete relationship episodes there were six identified wishes (Ws), one identified response from other (RO) and eight responses to self (RS). Of the 16 relationship episodes, 94% (15/16) had perfect agreement regarding which component was used (Ws, ROs, RSs) and 100% agreement (10/10) regarding positive and negative valence. The percentage of agreement between the two judges on the clustered standard categories was 100% (6/6) for wishes, and 50% (1/2) for (ROs) and 89% (8/9) for responses of self (RSs).

Of the six relationship wishes, the most common Ws came from wish cluster #5: "to be close and accepting" with 10 identifications by the component coders. The most common wish components were "to be opened up to" and "to have trust" with six identifications by the component coders. The most common RO cluster was cluster #7: "likes me" with the most common RO components being "respects me" with two identifications by the component coders. The most common RS came from cluster #7: "disappointed and depressed" with 15 identifications by the component coders. The most common RS component was the negatively valed "disappointed," with six identifications by the component coders. The weighted kappa cluster agreement for the 16 incomplete relationship episodes was .75. The weighted kappa cluster agreement for the therapy session CCRT component coders was as follows: Ws =

.78, ROs = .33, and RSs = .78. For further explanation of the aforementioned findings, please consult chapter five.

Table 4.1
CCRT SCORESHEET

Therapist: X

Session: RAP Interview

Number of Scoreable RE: 12

	Wish, Need, Intention				Response From Other				Response Of Self					
	RE Rater #1A				RE Rater #1B				RE Rater #1C					
	A	B	C	Total	A	B	C	Total	A	B	C	Total		
A. To Be Respected	3	5	2	10	A. No Understanding	2	2	2	6	A. Disappointed	4	5	1	10
B. To Be Accepted	3	4	1	8	B. Don't Respect Me	3	3	0	6	B. Helpless	2	2	5	9

TABLE 4.2

Client #1: TAQ SCORES ACROSS 5 SESSIONS

	SESSION 1	SESSION 2	SESSION 3	SESSION 4	SESSION 5	<i>M</i>	<i>SD</i>
THREAT	11	6	13	14	12	11.2	3.11
HARM	9	6	12	10	5	8.4	2.88
CHALLENGE	6	5	3	6	5	5	1.22

TABLE 4.3

Client #2: TAQ SCORES ACROSS 5 SESSIONS

	SESSION 1	SESSION 2	SESSION 3	SESSION 4	SESSION 5	<i>M</i>	<i>SD</i>
THREAT	5	N/A	2	7	5	4.75	2.06
HARM	0	N/A	2	0	0	0.5	1
CHALLENGE	15	N/A	17	17	12	15.25	2.36

TABLE 4.4

Client #3: TAQ SCORES ACROSS 5 SESSIONS

	SESSION 1	SESSION 2	SESSION 3	SESSION 4	SESSION 5	<i>M</i>	<i>SD</i>
THREAT	9	6	N/A	N/A	12	9	3
HARM	0	1	N/A	N/A	5	2	2.65
CHALLENGE	9	13	N/A	N/A	7	9.67	3.06

TABLE 4.5

Patient 1-3: TAQ SCORES ACROSS 15 SESSIONS

	1.1	1.2	1.3	1.4	1.5	2.1.	2.2	2.3	2.4	2.5	3.1	3.2	3.3	3.4	3.5	<i>M</i>	<i>SD</i>
THREAT	11	6	13	14	12	5	N/A	2	7	5	9	6	N/A	N/A	12	8.5	3.85
HARM	9	6	12	10	5	9	N/A	2	0	0	0	1	N/A	N/A	5	4.92	4.34
CHALLENGE	6	5	3	6	5	15	N/A	17	17	12	9	13	N/A	N/A	7	9.58	5

Chapter 5

Discussion

Restatement of the Problem

The primary purpose of this research was to empirically investigate whether the Core Conflictual Relationship Theme (CCRT) coding method, which has previously been used as a coding method for extracting clients' transference template(s), could be used as a systematic way to identify a therapist's respective countertransference template(s). In addition, this study attempted to not only identify, but also examine how a therapist's respective countertransference pattern might be activated throughout the course of a short-term therapy. Due to the extremely limited number of studies that have utilized the CCRT coding method as a countertransference measure, and none (within the author's awareness) whose sole purpose has been to validate the CCRT coding method as a viable countertransference coding method, this study was viewed as a starting point from which a line of future CCRT countertransference studies could emerge.

Broad Research Questions

While contemplating the current study, three central research questions materialized. First, can the CCRT, a coding system that has been historically used to identify a client's core conflictual relationship theme, be used without modification to successfully detect a therapist's countertransference core conflictual relationship theme? Second, once extracted, will a therapist's respective CCRT become evident throughout the course of therapy? Finally, in regards to Hayes and Gelso's (2007) integrative definition of countertransference, is a therapist's CCRT pervasive or does it only become evident with certain types of clients who provide an activating unresolved

conflictual issue stemming from the therapist's past and/or a therapy related event that provoked a countertransference manifestation?

Discussion of Primary Analysis

Several aspects of the primary analysis are notable. First, the RAP interview method continues to exhibit efficacy as a method for quickly extracting an individual's core conflictual relationship theme or transference template (Barber, Luborsky, Crits-Christoph, & Diguier, 1995). However, while this is a relatively accepted finding by previous CCRT researchers who have examined transference phenomena, the current study employed the RAP to examine possible countertransference origins, in terms of wishes, triggers, in terms of responses from others, and affect, actions, or self-representations in terms of response to self (Levenson, Butler, Powers, & Beitman, 2008). Thus, a slightly modified two-step process was adopted to complete this task. In hopes of comparing a therapist's extracted countertransference template from the RAP interview with possible countertransference material revealed in the therapist's talking turns during sessions, the traditional transference RAP interview was first conducted. Once the therapist's CCRT was extracted from the RAP interview, talking turns of the therapist during selected therapy sessions were then analyzed for subsequent CCRT session material.

Of the 14 transcribed psychotherapy sessions, 0 complete relationship episodes (rated by coders over 2.5 on completion scale) were found. Thus, utilization of the standard coding method was rejected as a viable method for examining countertransference manifestations. However, due to the nature of this study, which was exploratory in nature, the examination of incomplete relationship episodes (below 2.5 on

the completeness scale) was regarded as reasonable. This deviation from the normal CCRT protocol was completed to determine whether or not the CCRT coding method could be used as a countertransference coding method with modifications from the standard procedure. Additionally, it was done to examine whether or not incomplete relationship episodes might exhibit parts of the CCRT, such as specific countertransference origins, triggers, or affective responses (Levenson et al., 2008).

Based on the CCRT extracted from the RAP interview, the most pervasive wish was “to be loved and understood,” with the central wish component being “to be respected.” In psychotherapy sessions, the therapist’s most common wish was “to be close and accepting” with the most common components being “to be opened up to” and “to have trust.” An example from a transcribed session where two coders found evidence of the therapist’s wish “to be close and accepting” was as follows:

Example #1

Therapist: *Ok... and I will pick up on that, and we'll go from there so I don't want...My worry, I guess...I don't want to like steer you in a direction you don't want to go but ummm...or feel forced to talk about something. So, you let me know if it's feeling that way, or I'm pushing too much or anything like that.*

As can be seen, the material within the above relationship episode (rated a 1.5 in completeness) does not have much content material to analyze. However, despite its minimal content, there still may be an abundance of countertransference material within it. First, the context from which it comes must be examined. The particular client in the

aforementioned therapeutic snippet was a female, first-year student who had recently suffered a concussion during a sporting event. Though coping with the head injury was the presenting problem, the client revealed during her first therapy session that her father had molested her as a child, and was currently physically abusing her. This context may give insight into the therapist's departure from otherwise sound sentence structure towards a stammering core message within the above excerpt. While the author of this study realizes there are other possible interpretations, the differences between the therapist's interactions during particular sessions with this client (client #1), and other recorded sessions with other clients are striking. For instance, in the following excerpt, the therapist is talking to another client (client #2) whose mother recently visited his college to help him decide whether or not he should quit school:

Example #2

Therapist: *Ok, good. I'm glad she still came up and you talked through pros and cons. I notice sometimes it's like the grass is greener on the other side type of thing. Like, "If I go home it will be great, it will be relaxing, I'll feel better." It's like good for a few days and then it's like, "Now what do I do?" type of thing, you know?*

As can be clearly seen, the therapist smoothly details her thoughts without any notable stammering, starting and stopping, or consistent checking in. Thus, this comparison, taken in conjunction with a score of 5 on the TAQ individual item "anxious" (the highest possible score) during the particular session makes it not unreasonable to think the therapist may have been struggling with state anxiety throughout the session.

Further, it has been well documented that state anxiety has often been operationalized quite successfully as an emotional indicator for countertransference manifestations (Gelso & Hayes, 2007). Accordingly, if this speculation is correct, the therapist's anxiety may have driven the therapist into the type of jumbled narrative she conveyed to the client. Put simply, the therapist may have felt anxious due to the session material. This anxiety may have caused an overt manifestation in the form of a lack of smoothness in the therapist's speech. In other words, the content of the client's material triggered an affective countertransference reaction (anxiety) that subsequently gave rise to a behavioral countertransference reaction (stammering, checking-in, etc.). To summarize, then, from looking at other session material, the therapist's transference template wish usually occurs in cluster #5 "to be close and accepting" with the components most often being "to be opened up to" or "to have trust." Thus, the manifestation, "to be opened up to," or "to have trust" may be the therapist's default reaction when anxious moments arise throughout therapy.

However, this interpretation would not explain why the therapist's RAP CCRT wish comes from cluster #6 "to be loved and accepted," while the session CCRT wish cluster comes from cluster #5, "to be close and accepting." The author believes that this question may reflect the solid training the seasoned therapist has received during her career, and at her current training site. Put simply, it would be much more appropriate and professional to wish, "to be close and accepting," rather than "to be loved and understood," in regards to a client. Though closely related, the former resonates with a humanistic approach to therapy while the latter seems to indicate a countertransference manifestation. Additionally, it is possible according to Freudian theory that we all have

one, or *perhaps several*, transference templates. Further, also in accordance with psychoanalytic theory, it may be the case that an individual who consistently wishes “to be loved and understood,” in intimate familial relationships would have a slightly modified wish to be “close and accepting” as a therapist. This would not be a far-fetched aberration, especially when juxtaposed with other possible CCRT clusters such as wish cluster #4: “to be distant and avoid conflicts” (Freud, 1912/1958a).

The therapist’s most common response from other (RO) during the RAP interview had a negative valence and came from cluster #5: “rejecting and opposing.” The most common RO components detailed that others were “not understanding,” and “don’t respect me.” However, the most common ROs during the session material came from cluster #7 “likes me” with the most common components having a positive valence “respects me.” It is possible that in the professional setting, where one is the presumed expert, an individual with a more negative clustered template, might work especially hard to change the common negative response from other to a more positive, more desired response from other. It is even possible that those who commonly struggle with feeling respected in their personal lives may seek professions where getting respect or being seen as “expert” is a secondary gain. This being said, as there was only one agreed upon RO throughout the session material, the author believes it is exceedingly risky to interpret much from such an infrequently occurring result.

Finally, the most common response of self during the therapist’s RAP interview had a negative valence and came from cluster #7 “disappointed and depressed” with the most common components being “disappointed” and “helpless.” The corresponding session material also came from cluster #7, with the most common component being

“disappointed.” The following excerpt came from client #1’s first session regarding the past abuse experienced by her parents.

Example #3:

Therapist: *That seems...that makes me sad, you know, like, to know that a child is going around with that message from their parents, you know?*

Due to the intense nature of the session, one might predict that working with a client who has been abused from a young age might straightforwardly lead the therapist into the “disappointed and depressed” cluster. Thus, given the nature of this information, the response may not be a countertransference manifestation at all. However, while this may certainly be the case, it might also indicate more nuanced countertransference material. This particular therapist’s extracted RAP CCRT tells us that the most common or familiar RS the therapist seems to gravitate towards occurs in cluster #7: “disappointed and depressed.” In other words, though seemingly appropriate in this session’s context, the therapist may also be routinely returning to this particular response cluster because it is a familiar part of her own personal countertransference template. Additionally, the therapist repeatedly self-discloses her “sadness” multiple times throughout this particular client’s sessions. Here are another two self-disclosing examples that came from separate sections of another session (client #1, session #3) transcript:

Example #4:

Client: *I just...left the house.*

Therapist: *Okay...and that makes me sad to hear that he, like, hit you in the face.*

Example #5:

Therapist: *Wow. I get sad hearing this, you know? Like, because it makes me sad that you're experiencing this, you know? I just wonder, like, when you say that, like what is it like to say, "My nose was bleeding?" Like, how does that feel to say?*

Taken collectively, this study's results seem to illustrate a major issue in countertransference research; that is, is the material we are looking at something that stirred countertransference manifestations within this particular therapist, or would this information cause a similar reaction in any therapist? Or inversely, if we are to look at countertransference as a phenomenon stirred up by our own unresolved issues, and these issues can be identified by component categories in the CCRT coding method, then could responses, which are seemingly appropriate during particular situations, actually be countertransference manifestations? This possibility is furthered when examining the therapist's self-reported TAQ scores. As previously reported, none of the therapist's TAQ scores met this study's criterion for "atypical" behavior of being 2.0 standard deviations away from the mean across individual clients or across the 14 recorded sessions. However, the author of this study chose to examine those responses one standard deviation away from the mean as possible indications of more nuanced countertransference manifestations. Results indicated that across 14 recorded sessions, 12 scores were one standard deviation away from the mean. Strikingly, of those 12, 9

happened in conjunction with elevations in another TAQ subscale (Threat, Harm, Challenge). Equally as striking, in the session (session #1.3) with the most REs, and the previously discussed self-disclosures, the Threat and Challenge subscales were at least one standard deviation higher when compared to the rest of client #1's sessions. Furthermore, the Threat, Harm, and Challenge scores for this session were at least one standard deviation above the mean from all 14-recorded sessions.

To sum up the answer to the first question asked, "Can the unmodified CCRT, a coding system that has been historically used to identify a client's core conflictual relationship theme, be used to successfully detect a therapist's countertransference core conflictual relationship theme?" the answer is based on this study, there is not enough evidence in the current data to answer in the affirmative. However, because this study used only one therapist, with so few cases (3) and so few sessions (14), further research is warranted. In fact, with modification, it is the author's belief that the CCRT coding method shows real promise regarding the identification of countertransference origins, and affective manifestations during sessions in the forms of wishes and responses from self. Though it is still up for debate whether or not the CCRT can be used to reliably locate countertransference triggers in the form of the response from other (RO) within session material, this study failed to provide conclusive evidence to the point and appeared to illuminate a central issue - namely, it is rarely, if ever, known how the therapist interprets the response from the patient within the moment it occurs or how it may activate the therapist's CCRT template. Thus, without definitive therapist statements, coding this component using the CCRT is almost impossible as even if a RO result was successfully coded as implied, it could be argued to be little more than a

successful coding of conjecture. Though implication is often the case with the other two components, coding ROs becomes exceedingly difficult with implication as it requires the coders to assess what the patient said or how he/she acted at a particular time in the session, how the therapist took the response or behavior, and how it manifested itself within the RO component. This study's findings aligns with Gelso & Hayes' (2007) summation that useful generalizations about the kinds of patient material that will trigger countertransference reactions are difficult to make with much accuracy. The participating therapist in this particular study rarely discussed the patient's behavior during the session. Thus, the RO component was only coded twice throughout the 14 audio-recorded sessions and the accuracy with which it was coded was minimal, at best. However, it should be noted that within certain therapeutic modalities, such as those within the interpersonal therapy realm, this type of response might be more common, and considered proper technique. Therefore, this particular CCRT component demands further attention within in future examinations.

The second question asked during this study, "Once extracted, will a therapist's respective CCRT become evident throughout the course of therapy?" was answered with a partial affirmative. With modification, specifically looking at incomplete relationship episodes, it was possible to identify countertransference material throughout the course of therapy, especially regarding responses to self. Wishes were also identified, but though close in nature, seemed to morph into a more professionally accepted form. There were not enough responses from other(s) collected to make any sort of definitive affirmation or refutation.

Finally, again using Gelso and Hayes' (2007) integrative definition of countertransference, it was questioned whether or not a therapist's respective CCRT would be activated by certain types of clients who provided the necessary activating "hooks" or "triggers" during the therapeutic hour. A "hook" was operationalized by an unresolved conflictual issue stemming from the client's past and was expressed as a CCRT wish (W) component. A "trigger" was operationalized as a therapy related event that provoked a countertransference manifestation, and for this particular study, was expressed as a CCRT response from other component (RO). As stated in chapter four, this question was contingent upon the answering of question one and therefore did not lead to a confirmation or refutation, as it was found that during this project activating "hooks" and/or "triggers" did not manifest in an expressed exhibition of the participating therapist's CCRT. However, it is notable that though there were no complete exhibitions of the therapist's CCRT, consistent CCRT material was present throughout a few of the sessions when traditional CCRT coding rules were modified and incomplete relationship episodes were examined. Of the 16 incomplete relationship episodes documented throughout the 14 audio-recorded sessions, 5 (31%) were found in a single session (session #1.3). This particular session also had elevations in all three subscales (1.0 standard deviation away from the mean) on the TAQ both within client #1's sessions, and across all three clients. As previously stated, this may be an indication that countertransference manifestations were occurring during the particular session, albeit in a more nuanced manner than could be captured by the traditional CCRT coding method.

Implications for Therapy

Despite the previously stated short-comings of the traditional CCRT coding method as a countertransference coding method, the author of this study believes there may still be a great deal of utility for clinicians and supervisors who utilize a modified version of the CCRT coding method to identify chronic relationship themes that could prove detrimental to therapy. This may be especially true for longer-term therapies where lacking contemporary time constraints, there is more of a chance for interpersonal dynamics to develop. Additionally, in the spirit of Freud's idea of self-analysis, much can be learned by an individual clinician and his/her supervisor through the simple administration, and subsequent coding of a RAP interview. Discovering a given therapist's CCRT could supplement, or serve as a stopgap for the often-incomplete nature of the self-analytic process. As Freud writes, "In self-analysis the danger of incompleteness is particularly great. One is too soon satisfied with a part explanation, behind which resistance may easily be keeping back something that is more important" (1935/1964, p. 234). In addition, utilizing the CCRT during the supervision process may aid with therapist self-insight, empathy, self-integration, anxiety management, and conceptualizing ability, factors that have previously been shown to reliably aid countertransference management (Gelso & Hayes, 2007). For instance, the concept of self-insight could be assisted by having the therapist reflect on his/her extracted CCRT during the supervision hour in hopes of illuminating potential blind spots throughout the course of therapy. Recent research on self-insight and countertransference buttresses the idea that self-insight plays a role in therapists' use of countertransference reactions in the service of effective therapeutic interventions. Thus, this type of insight regarding

countertransference reactions might also be thought to foster a therapist's conceptualizing ability (Dadlani, 2011). Regarding empathy, utilizing the CCRT as a supervision tool might give the therapist more of an understanding and insight regarding the often cyclical nature of problems his/her clients are often struggling with. The CCRT might also be used to begin the exploration process necessary for self-integration. In addition, recognizing, acknowledging, and working from the knowledge of one's own CCRT may have an inoculating effect on both trait and state anxiety. In other words, understanding particular issues that may activate one's anxiety as well may empower the therapist moving forward, rather than having him/her become blindsided during a session that is full of countertransference laden material. Finally, by utilizing the CCRT as a tool to understand one's self, as well as the cyclical patterns illustrated within one's countertransference template, the therapist's conceptualizing ability regarding clients might be greatly aided. However, while this knowledge certainly makes the CCRT sound like an excellent supervision tool, specifically in the metatherapeutic approach to supervision, the need for boundaries is essential to providing a safe, stable supervisory environment (Levenson, 1982). Thus, a discussion regarding how the CCRT as a supervision tool could be potentially rewarding and/or damaging should be explored and weighed by any supervisory alliance before moving forward.

Implications for Research/Future Directions

This study's findings seem to resonate with other countertransference research that has indicated countertransference manifestations may not always come forth as emboldened or flagrant displays of unchecked affects or behaviors. As seen in this study, many times countertransference material may take on a more nuanced presentation, and

often times brings into question if the countertransference reaction is due to an unresolved issue from the therapist's past, or is a reaction any therapist would have, given the exact situation. Thus, it may behoove psychotherapy researchers to undertake the creation of a systematic inventory of what could be defined as "unconscious." To do this most effectively, future researchers may need to move away from the field of psychoanalysis. The thought behind this suggestion is that by first taking an inventory of what is often considered "unconscious," and moving it away from the field of psychoanalysis, researchers may first try to explain what is going on in more behavioral and affective terminology. This may lead to the operationalization of many of the more borderline mystical traits of countertransference manifestations commonly seen in the psychoanalytic literature. This venture might also open more collaboration between theoretical models. For instance, if researchers begin to examine the antecedent ideas regarding the unconscious and subsequent countertransference manifestations, it may allow for discussions around newer ideas regarding the phenomenon. This type of research has already begun in certain psychotherapy research sectors. Pincus, Freeman, and Modell (2007) have looked at the transference and countertransference phenomena through the lens of perception, and propose that it is pervasive in humans and when not impaired, is an adaptive ego function that emerges within any significant interpersonal situation. Another recent study has examined contextualized role-forming in evolutionary and social contexts in hopes of examining countertransference in light of basic social-processing models and (Marcus & Buffington-Vollum, 2005). By moving the field of research and theory from the psychoanalytic realm, it may be possible to reconnect it

with previous theory such as Lacan's (1954/1991)'s premise that all meaningful speech is transference in light of the research on perception put forward by Pincus et al., (2007).

Further, a systematic, empirically supported, classification system of what is thought to be unconscious, preconscious and conscious could lead to operationalization and subsequent validation (or invalidation) of terms that have long pervaded the literature. This need became increasingly evident within this study when it became unclear whether or not the therapist's reactions to client material was normal, as in any therapist would have experienced similar reactions, or atypical and thus, a countertransference manifestation. The data quickly became murkier when attempting to elucidate the difference between unconscious material (the CCRT template), preconscious material (the therapist's identity, identification as therapist, ideas that can be readily brought to the surface), and conscious (what was occurring in the current moment) as well as their respective interplay. Put simply, it may be necessary to better understand the nature of the unconscious before trying to "capture" it empirically.

Additionally, countertransference researchers may need to reexamine commonly utilized countertransference research methods, such as self-report measures and basic transcript review, as this study seems to indicate it is extremely important to examine what is being said during the therapeutic hour in the context of who it is being said to, and how it is being relayed from therapist to client (Rosenberger & Hayes, 2002). To effectively execute this sort of research, the author of this study suggests the application of modern technological advances and change process research methods that seek to examine the moment-by-moment interactions between the therapist and the client in hopes of isolating causation (Kazdin, 2009). Some contemporary countertransference

research has already begun to take on this complicated endeavor. For instance, Rosenberger and Hayes (2002) used sequential analysis to examine 600 plus individual speaking turns in a case study on countertransference. Employed collectively with coding methods such as the CCRT, these sort of methods may lead researchers toward the multi-layered, deeply embedded material in the therapist's psyche that resides largely outside of awareness (Gelso & Hayes, 2007). However, if we are to ever validate countertransference phenomena, and/or unconscious processes in general, the author of this study believes it is imperative that researchers look to combine present-day technological advances with previously employed research methods, such as self-report methods, and coding methods such as the PERT or CCRT in hopes of triangulating research findings to bring us closer to an understanding of the phenomena.

Building off of the current study, it could prove useful in future research to take more of a systematic approach to identifying problematic sessions. For instance, though 14 sessions were transcribed and coded, only 2-3 seemed likely to have problematic countertransference manifestations. In hindsight, when examined with the therapist's self-reported TAQ, these sessions were identifiable before they were transcribed. Therefore, future researchers may save critical time and resources if this finding could be consistently replicated. If the TAQ is not available, or does not prove to be reliable in future studies, then utilizing a therapist's respective supervisor may also prove beneficial when identifying difficult sessions. In a best-case scenario, both the RAP and supervisor would be utilized to identify aberrant sessions. Sessions where the TAQ is deviant from the baseline would alert supervisors and therapists to further consider identifying the session as aberrant from normal session material. It may prove particularly useful to

examine those clients who are deteriorating in hopes of identifying what may be considered “harmful countertransference.”

Summary

While the direct effects of countertransference are not clear, evidence suggests that countertransference may weaken the therapeutic alliance, and therefore negatively, albeit indirectly, influence therapeutic outcome (Castonguay & Beutler, 2006; Hayes, Gelso, & Hummel, 2011). Thus, it is imperative that psychotherapy researchers continue to unearth methods of examining countertransference related phenomena such as countertransference origins, triggers, and their respective interplay. However, this study’s findings suggest that without modification, it is unreasonable to expect that the CCRT method, as applied to therapy transcripts, can capture much in the way of CT. There just aren’t enough RE’s, or complete RE’s, in the therapy session and, in retrospect, that is probably not a surprise. One might wonder about a therapist who talks so openly about himself/herself where complete RE’s are evident. On the other hand, the CCRT method may reveal some interesting information regarding unconscious wishes as the basis for countertransference origins, which have been extremely hard to detect using previously utilized methods (Gelso & Hayes, 2007). This alone represents a valuable contribution to the research literature. In addition, the CCRT shows a capacity to capturing and subsequently categorize affective countertransference behavior as coded by the CCRT component, response to self (RS). Finally, the RAP interview seems to hold much promise as a way of identifying a given therapist’s countertransference template—even if therapy sessions themselves did not provide much validation for what was uncovered using the RAP interview.

In sum, this study's findings suggest that the participating therapist's core conflictual relationship theme was successfully extracted utilizing the CCRT's RAP interview, and was present, albeit incrementally, during the course of therapy. It is the author's belief that this incremental finding speaks to the larger, more nuanced issue regarding the elusive nature of unconscious material and seems to resonate with Freud's (1912/1958a) theory that each individual creates a single, or perhaps several, templates that will consistently be repeated throughout the course of an individual's life with respect to the individual's external circumstances, and the nature of what the available love objects will sanction. In other words, every person has one or perhaps several ways they relate to the world which will be repeated indefinitely throughout a person's life with respect to an individual's situation and the nature of what individuals around him/her will allow. In the particular case of this study, the key part of the Freudian axiom may likely be seen as, "with respect to the individual's external circumstances, and the nature of what the available love objects will sanction" (1912/1958a, p. 312-313). An example of this occurred during this study while comparing the therapist's RAP wish to the therapist's session wish material. While this study's participating therapist's extracted RAP CCRT wish came from cluster #6 "to be loved and understood," and was "to be respected," the more professional and socially acceptable #5 cluster, "to be close and accepting" with components, "to be opened up to" and "to have trust," were present during the therapist's psychotherapy sessions. Although the RAP interview and session material differ, the difference is minor in comparison with other clusters. Thus, it may be the case that as Freud (1912/1958a) suspected over 100 years ago, transference (or in this case, countertransference) material may morph into professionally or socially acceptable

conversions based on the current life situation. If this is the case, future research might look at when these conversions are most likely to occur, and when these conversions move into more blatant, toxic manifestations of more rigid templates. There is some preliminary research on which to base these future examinations. For instance, Cierpka, et al. (1998) found that the consistency of relationship patterns in CCRT narratives seemed to be correlated with the severity of psychopathology in the comparison of inpatient and outpatient settings.

Overall, this study added to the existing wealth of countertransference literature by examining a new research method used to investigate countertransference phenomena through an examination of countertransference origins. This method could be particularly helpful within the supervision process, as it would likely save time and resources by helping therapists and supervisors quickly identify possible problem areas originating in the therapist's past, as well as how these problem areas would likely manifest with given clients. Additionally, this research study has also advanced the existing countertransference knowledge base by illustrating how we as researchers might identify and isolate countertransference manifestations within sessions by utilizing Fauth's (2006) idea regarding countertransference research methodology: the use of outside raters has great potential for unearthing deeper unconscious countertransference origins. It is recommended that future studies attempt to replicate this study with more clients and more therapists, in hopes of elucidating the current findings while considerably adding to the knowledge base.

Limitations

This study has a number of inherent limitations. First and foremost, the author of this study knew the participating therapist, as they were in the same training program. This could have seriously impacted the therapist's responses to both the RAP and TAQ.

Second, there is a question of generalizability. While there seems to be some indication that the CCRT may be able to indicate *possible* countertransference origins, this particular study only examined the interactions between one therapist and three of the therapist's clients. Thus, the findings of this study may be particular to the participating therapist, the participating clients, or a combination of the participating therapist and participating clients. Further, the aforementioned results may simply be indicative of the particular interplay between the aforementioned parties rather than providing any grand statement about the nature of countertransference.

Third, "atypical" TAQ scores were originally operationalized as two or more standard deviations away from the mean but due to the largely speculative nature of the study, and elevated endorsements below two standard deviations but above one standard deviation from the mean, criterion was adjusted to one or more standard deviation from the mean in hopes of examining any elevations in scores. Taken in conjunction with other, incomplete CCRT material, it is believed there may be valuable data to be found by re-operationalizing the concept of "atypical" concerning TAQ subscale endorsements. Thus, there is an argument for disregarding the collected data between 1 standard deviation and 2 standard deviations, which this study largely relied on when examining the TAQ.

In addition, this study also modified the traditional CCRT parameters in hopes of finding any evidence of partial countertransference manifestations by examining

incomplete relationship episodes (below a 2.5 on the CCRT completeness scale). While this has historically been frowned upon in CCRT studies, this study suggested that due to the incomplete nature of countertransference manifestations, an unorthodox manner of examining incomplete relationship episodes might be warranted. However, this sort of examination requires replication, as it has rarely been done and may therefore cause the results, albeit small, to be more important than they in fact are.

Another limitation to this study was the interval within which the data was collected and coded. Due to the recruitment process, some of the CCRT codings were completed later in the nearly year and a half this study took to complete than others. Thus, the coders may have been less prepared during the later coding sessions than when the trainings were fresh on their respective minds. It is recommended that future studies collect data before training the respective coders, as this may limit these sorts of issues from occurring.

Finally, this study, largely exploratory in nature, was limited by the lack of previous research utilizing the CCRT as a means for measuring countertransference origins, triggers, and affective manifestations. While other research has used it in conjunction with other areas of research (for instance, attachment theory), no prior study has looked at its validity as a countertransference measure (Wiseman and Tishby, 2010). Therefore, this initial study, though important, was limited in its scope due to the lack of previous validation.

References

- Alexander, F. (1961). *The scope of psychoanalysis*. New York: Basic Books.
- Apfelbaum, B. (1958). *Dimensions of transference in psychotherapy*. Berkley: University of California Press.
- Arlow, J. (1961). Ego psychology and the study of mythology. *Journal of the American Psychoanalytic Association*, 9, 371-393.
- Arlow, J. (1969a). Fantasy, memory, and reality testing. *Psychoanalytic Quarterly*, 38, 28-51.
- Arlow, J. (1969b). Unconscious fantasy and disturbances of conscious experience. *Psychoanalytic Quarterly*, 38, 1-27.
- Baehr, A. P. (2004). *Wounded healers and relational experts: A grounded theory of experienced psychotherapists' management and use of countertransference*. Pennsylvania State University. Unpublished doctoral thesis.
- Balint, A., & Balint, M. (1939). On transference and counter-transference. *International Journal of Psycho-analysis*, 20, 223-230.
- Balint, M. (1942). Ego strength and education of the ego. *The Psychoanalytic Quarterly*, 11, 87-95.
- Bandura, A., Lipsher, D. H., & Miller, P. E. (1960). Psychotherapists' approach-avoidance reactions to patients' expressions of hostility. *Journal of Consulting Psychology*, 24, 1-8.
- Barber, J. P., Crits-Christoph, P. & Luborsky, L. (1998). A guide to the CCRT standard categories and their classification. *Understanding transference: The core*

- conflictual relationship theme method*. (2nd ed.). Washington, DC: American Psychological Association.
- Barber, J. P., Foltz, C., & Weinryb, R. M. (1998). The central relationship questionnaire: Initial report. *Journal of Counseling Psychology, 45*(2), 131-142. doi: 10.1037/0022-0167.45.2.131
- Barber, J. P., Luborsky, L., Crits-Christoph P., & Diguier, L. (1995). A comparison of core conflictual relationship themes before psychotherapy and during early sessions. *Journal of Consulting and Clinical Psychology, 63*(1), 145-148.
- Benjamin, L. S. (1986). Operational definition and measure of dynamics shown in the stream of free associations. *Psychiatry, 49*, 104-129.
- Binswanger, L. (1913/1957). Letter from Dr. & Frau Binsanger to Freud, January 26th, 1913. In G. Fichtner (Ed.), *The Sigmund Freud-Ludwig Binswanger Correspondance 1908-1938*. London: Open Gate Press.
- Bion, W. (1962). *Learning from experience*. New York: Basic.
- Blos, P. (1941). *The adolescent personality: A study of individual behavior for the commision on secondary school curriculum*. New York: Appleton-Century-Crofts.
- Bourke, M. E., & Grenyer, B. F. S. (2010). Psychotherapists' response to borderline personality disorder: A core conflictual relationship theme analysis. *Psychotherapy Research, 20*(6), 680-691. doi:10.1080/10503307.2010.504242
- Bowlby, J. (1973). *Separation*. New York: Basic.
- Bowlby, J. (1979). Psychoanalysis as art and science. *International Review of Psychoanalysis, 6*(3), 3-14.

- Bowlby, J. (1988). *Secure Base*. New York Basic.
- Boyer, S. P., & Hoffman, M. A. (1993). Counselor affective reactions to termination: Impact of counselor loss history and perceived client sensitivity to loss. *Journal of Counseling Psychology, 40*(271-277.).
- Carlson, R. (1981). Studies in script theory: I. Adult analogs of a childhood nuclear scene. *Journal of Personality and Social Psychology, 40*, 501-510.
- Castonguay, L.G. & Beutler, L.E. (Eds.). (2006). *Principles of therapeutic change that work*. New York: New York: Oxford University Press, Incorporated.
- Chance, E. (1952). The study of transference in group therapy. *International Journal of Group Therapy, 2*, 40-53.
- Cierpka, M., Strack, M. Benninghoven, D., Staats, H., Dahlbender, R., Porkorny, Frevert, G. Blaser, G. Kächele, Geyner, M., Körner, A., & Albani, C. (1998). Stereotypical relationship patterns and psychopathology. *Psychotherapy and Psychometrics, 67*, 241-248.
- Cohen, J. (1968). Weighted kappa: Nominal scale agreement with provision for scaled disagreement or partial credit. *Psychological Bulletin, 70*, 213-220.
- Cohen, M. B. (1952). Countertransference and anxiety. *Psychiatry, 15*, 231-245.
- Comaz-Diaz, L., & Jacobsen, F.M. (1991). Ethnocultural transference and countertransference in the therapeutic dyad. *American Journal of Psychiatry, 61*(3), 392-402.
- Connolly, M. B., Crits-Christoph, P., Demorest, A., Azarian, K., Muenz, L., & Chittams, J. (1996). Varieties of transference patterns in psychotherapy. *Journal of Consulting and Clinical Psychology, 64*(6), 1213-1221.

- Cooley, E.J., & Klingler, C.R. (1989). Academic attributions and coping with tests. *Journal of Social and Clinical Psychology, 8*, 359-367.
- Crisp, A. (1964a). An attempt to measure an aspect of transference. *British Journal of Medical Psychology, 37*, 17-30.
- Crisp, A. (1964b). Development and application of a measure of transference. *Journal of Psychosomatic Research, 8*, 327-335.
- Crisp, A. (1966). Transference symptom emergence and social repercussion in behavior therapy: A study of 54 treated patients. *British Journal of Medical Psychology, 39*, 179-196.
- Cruz, J. & Hayes, J. A. (2006). *Countertransference in termination: Therapist loss resolution and fear of intimacy*. Paper presented at the North American Society for Psychotherapy Research Conference, Burr Oak, Ohio.
- Dadlani, M.B. (2010). Countertransference behavior and alliance quality as a function of therapist self-insight (Unpublished Master's Thesis) University of Massachusetts-Amherst Amherst, Massachusetts.
- De Forest, I. (1942). The therapeutic technique of Sandor Ferenczi. *International Journal of Psychoanalysis, 23*, 120.
- Deutsch, H. (1926). Occult processes occurring during psychoanalysis. In G. Devereaux (Ed.), *Psychoanalysis and the occult*. New York: International Universities Press.
- Diguer, L., Barber, J. P., & Luborsky, L. (1993). Three concomitants: Personality disorder, psychiatric severity, and outcome of dynamic psychotherapy of major depression. *American Journal of Psychiatry, 150*, 1246-1248.

- Eagle, M. N. (2000). A critical evaluation of current conceptions of transference and countertransference *Psychoanalytic Psychology, 17*, 24-37.
- Epstein, L. & Feiner., A. H. (1988). Countertransference: The therapist's contribution to treatment. In B. Wolstein (Ed.), *Essential papers on countertransference* (pp. 282-303). New York: New York University Press.
- Ernsberger, C. (1979). The concept of countertransference as therapeutic instrument: Its early history. *Modern Psychoanalysis, 4*, 141-164.
- Fauth, J. (2006). Toward more (and better) countertransference research. *Psychotherapy: Theory, Research, Practice, Training, 43*(1), 16-31. doi:10.1037/0033-3204.43.1.16
- Fauth, J. & Hayes, J. A. (2006). Counselors' stress appraisals as predictors of countertransference behavior with male clients. *Journal of Counseling and Development, 84*, 430-439.
- Fauth, J., Hayes, J.A., Park, J. & Friedman, S. (1999). Pre-session countertransference: Counselor's appraisals, self-efficacy, and prognosis. Poster session presented at the annual meeting of the American Psychological Association, Boston.
- Ferenczi, S. (1919). On the technique of psychoanalysis. *Further contributions to the theory and technique of psychoanalysis*. (pp. 198-217). London: Hogarth Press.
- Fielder, F. E. & Senior, K. (1952). An exploratory study of unconscious feeling reactions in fifteen patient-therapist pairs. *Journal of Abnormal and Social Psychology, 47*, 446-453.
- Fink, B. (2007). *Fundamentals of psychoanalytic technique: A Lacanian approach for practitioners*. New York, NY: W.W. Norton & Company.

- French, T. & Wheeler, D. R. (1963). Hope and repudiation of hope in psycho-analytic therapy. *International Journal of Psychoanalysis*, 44, 304-316.
- Freud, S. (1932, June 2, 1932). [Letter from Sigmund Freud to Stefan Zweig. Letters of Sigmund Freud 1873-1939.].
- Freud, S. (1937/1950). Analysis terminable and interminable (J. Strachey, Trans.). In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 23). London: Hogarth Press. (Original work published 1937)
- Freud, S. (1953). The interpretation of dreams (J. Strachey, Trans.). In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud*. (Vol. 7). London: The Hogarth Press. (Original work published 1900)
- Freud, S. (1955). Studies on Hysteria. (J. Strachey, Trans.). In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. II). London: The Hogarth Press. (Original work published 1893-1895)
- Freud, S. (1958a). *The dynamics of transference*. (J. Strachey, Trans.). In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 99-108). London: Hogarth Press (Original work published 1912)
- Freud, S. (1958b). Remembering, repeating, and working through (J. Strachey, Trans.). In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 145-156). London: Hogarth Press. (Original work published 1914)

- Freud, S. (1959). Future prospects of psychoanalytic psychotherapy. (J. Strachey, Trans.). In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 11). London: Hogarth Press. (Original work published 1910)
- Freud, S. & Abraham, K. (1965). *A psychoanalytic dialouge: The letters of Sigmund Freud and Karl Abraham, 1907-1926*. In H.C. Abraham, & E.L.Freud, (Eds.). New York: Basic Books.
- Friedman, S. & Gelso, C. J. (2000). The development of the Inventory of Countertransference Behavior. *Journal of Clinical Psychology, 56*, 1221-1235.
- Gabbard, G. O. (2001). A contemporary psychoanalytic model of countertransference. *Journal of Clinical Psychology, 57*(8), 983-991. doi:10.1002/jclp.1065
- Gay, P. (2006). *Freud: A life for our time*. New York, N.Y.: W.W Norton & Company, Inc.
- Gelso, C. J. (2004). Countertransference and its management in brief dynamic therapy. In D. P. Charman (Ed.), *Core processes in brief psychodynamic psychotherapy* (pp. 231--250). Mahwah, NJ: Lawrence Erlbaum Associates.
- Gelso, C. J., Fassinger, R. E., Gomez, M. J., & Latts, M.G. (1995). Countertransference reactions to lesbian clinets: The role of homophobia, counselor gender, and countertransference management. *Journal of Counseling Psychology, 42*, 356-364.
- Gelso, C. J. & Hayes, J. A. (1998). *The psychotherapy relationship: Theory, research, and practice*. New York: John Wiley & Sons.

- Gelso, C. J. & Hayes, J. A. (2007). *Countertransference and therapist's inner experience: Perils and possibilities*. Mahwah, NJ: Lawrence Erlbaum Associates.
- Gill, M. (1982). The analysis of transference: Vol. 1, theory and technique. *Psychological Issues, 54*.
- Gill, M. & Hoffman., I. Z. (1982a). Analysis of transference: Studies of nine audio-recorded psychoanalysis sessions. *Psychological Issues(54)*.
- Gill, M. & Hoffman, I. Z. (1982b). A method for studying the analysis of aspects of the patient's experience of the relationship in psychoanalysis and psychotherapy. . *Journal of the American Psychoanalytic Association, 30*, 137-167.
- Goodman, L. A. (1961). Snowball sampling. *Annals of Mathematical Statistics, 32* 148-170.
- Graff, H. & Luborsky, L. (1977). Long-term trends in transference and resistance: A quantitative analytic method applied to four psychoanalyses. *Journal of the American Psychoanalytic Association, 25*, 471-490.
- Grenyer, B. F. S. & Luborsky, L. (1998). Positive versus negative CCRT patterns. In L. Luborsky & P. Crits-Christoph (Eds.), *Understanding transference: The core conflictual relationship theme method* (2nd ed., pp. 275-288). Washington, DC: American Psychological Association.
- Grenyer, B. F. S. (2002). *Mastering relationship conflicts: Discoveries in theory, reasearch and practice*. Washington, D.C.: American Psychological Association.
- Haule, J. R. (1986). Pierre Janet and dissociation: The first transference theory and its origins in hypnosis. *American Journal of Clinical Hypnosis, 29(2)*, 86-94. doi: 10.1080/00029157.1986.10402690

- Hayes, J.A. (2004). The inner world of the psychotherapist: A program of research on countertransference. *Psychotherapy Research* 14(1), 21-36.
- Hayes, J. A., Gelso, C. J., & Hummel, A. M. (2011). Managing countertransference. . In J. C. Norcross (Ed.), *Psychotherapy relationships that work: evidence-based responsiveness*. New York, NY: Oxford University Press.
- Hayes, J. A., McCracken, J. E., McClanahan, M. K., Hill, C. E., Harp, J. S., & Carozzoni, P. (1998). Therapist perspectives on countertransference: Qualitative data in search of a theory. *Journal of Counseling Psychology* 45, 468-482.
- Hayes, J. A. & Gelso, C. J. (1993). Male counselors' discomfort with gay and HIV-infected clients. *Journal of Counseling Psychology*, 40, 86-93.
- Hayes, J. A. & Gelso, C. J. (1991). Effects of therapist trainees' anxiety and empathy on countertransference behavior. *Journal of Clinical Psychology*, 47, 284-290.
- Haynal, A. E. (1996). Freud and his intellectual environment: The case for Sandor Ferenczi. In P. L. Rudnytsky, A. Bokay, & P. Giampieri-Deutsch (Eds.). *Ferenczi's turn in psychoanalysis*. New York and London: New York University Press.
- Heimann, P. (1950). Countertransference. *British Journal of Medical Psychology*, 33, 9-15.
- Hoffman, I. (1983). The patient as interpreter of the analysts' experience. *Contemporary Psychoanalysis*, 19, 389-422.
- Holmes, D. E. (1992). Race and transference in psychoanalysis and psychotherapy. *International Journal of Psychoanalysis*, 73, 1-11.

- Holmes, D. E. (1999). Race and countertransference: Two "Blind Spots" in psychoanalytic perception. *Journal of Applied Psychoanalytic Studies*, 1(4), 319-332.
- Horowitz, M. J. (1979). *States of mind: Analysis of change in psychotherapy*. New York: Plenum Press.
- Janet, P. (1925). *L'influence somnambulique et la besoin de direction*. (4th ed. Vol. 1). Paris: Alcan. (Original work published 1898)
- Janet, P. (1976). Psychological healing: A historical and clinical study. (E. P. Paul, C., Trans.). New York: Arno Press. (Original work published 1919)
- Janet, P. (1977). The mental state of hystericals. (C. R. Corson, Trans.). In D. N. Robinson (Ed.), *Significant Contributions to the History of Psychology, Series C, Medical Psychology* (Vol. 11). Washington DC: University Publications of America. (Original work published 1892)
- Jung, C. G. (1972). *Synchronicity: An acausal connecting principle*. (R. F. C. Hull, Trans. Vol. 8). Princeton, NJ: Princeton University Press. (Original work published 1935)
- Kazdin, A.E. (2009). Understanding how and why psychotherapy leads to change. *Psychotherapy Research*, 19, 419-428.
- Kernberg, O. F. (1965). Notes on countertransference. *Journal of the American Psychoanalytic Association*, 13, 38-56.
- Kiesler, D. J. (1996). *Contemporary interpersonal theory and research: Personality, psychopathology, and psychotherapy*. New York: Wiley.

- Kiesler, D. J. (2001). Therapist countertransference: In search of common themes and empirical referents. *Journal of Clinical Psychology, 57*(8), 1053-1063.
- Klein, M. (1946/1952). Notes on some schizoid mechanisms. In J. Riviere (Ed.), *Developments in psycho-analysis* (pp. 292-320). London: Hogarth.
- Kraus, M. & Chen, S. (2010). Facial-feature resemblance elicits the transference effect. *Psychological Science, XX*(X), 1-5.
- Lacan, J. (1991). *The Seminar of Jaques Lacan, Book II, The Ego in Freud's Theory and in the Technique of Psychoanalysis*. London: Norton.
- Landis, J., & Koch, G. (1977). The measurement of observer agreement for categorical data. *Biometrics, 33*(159-174).
- Laplanche, J. P., & Pontalis, J.-B. (1973). *The Language of Psycho-Analysis*. New York: Norton.
- Latts, M. G., & Gelso, C. J. (1995). Countertransference behavior and management with survivors of sexual assault. *Psychotherapy, 32*, 405-415.
- Levenson, H., Butler, S.F., Powers, T.A. Beitman, B.D. (2008). *Concise Guide to Brief Dynamic and Interpersonal Therapy*. Washington D.C.: American Psychiatric Publishing, Incorporated.
- Levenson, E. A. (1982). Following the fox: An inquiry into the vicissitudes of psychoanalytic supervision. *Contemporary Psychoanalysis, 18*, 1-15.
- Luborsky, L. (1976). Helping alliances in psychotherapy: The groundwork for a study of their relationship to its outcome. In J. Claghorn (Ed.), *Successful psychotherapy* (pp. 92-116). New York: Brunner/Mazel.

- Luborsky, L. (1998a). The convergence of Freud's observations about transference with the ccrt evidence. In L. Luborsky & P. Crits-Christoph (Eds.), *Understanding transference: The core conflictual relationship theme method* (2nd ed., pp. 307-326). Washington, DC: American Psychological Association.
- Luborsky, L. (1998b). The everyday clinical uses of the ccrt. In L. Luborsky & P. Crits-Christoph (Eds.), *Understanding transference: The core conflictual relationship theme method* (2nd ed., pp. 275-288). Washington, DC: American Psychological Association.
- Luborsky, L. (1998c). The relationship anecdotes paradigm (RAP) interview as a versatile source of narratives. In L. Luborsky & P. Crits-Christoph (Eds.), *Understanding transference: The core conflictual relationship theme method* (2nd ed., pp. 109-120). Washington, DC American Psychological Association.
- Luborsky, L., Crabtree, L., Curtis, H., Ruff, G., & Mintz, J. (1975). The concept of "space" of transference for eight psychoanalysts. *British Journal of Medical Psychology, 48*, 65-70.
- Luborsky, L., Crits-Christoph, P., & Mellon, J. (1986). Advent of objective measures of the transference concept. *Journal of Consulting and Clinical Psychology, 54*(1), 39-47.
- Luborsky, L., Graff, H., Pulver, S.S., & Curtis, H. (1973). A clinical-quantitative examination of consensus on the concept of transference. *Archives of General Psychiatry, 29*, 69-75.

- Luborsky, L., Mellon, J., Alexander, K., van Ravensway, P., Childress, A. Levine, F., Cohen, K. D., Hole, A. V., & Ming S. (1985). A verification of Freud's grandest clinical hypothesis: The transference. *Clinical Psychology Review, 5*, 231-246.
- Luborsky, L., & Crits-Christoph, P. (1998). *Understanding transference: The core conflictual relationship theme method*. (2nd ed.). Washington, DC American Psychological Association.
- Luborsky, L., & Diguier, L. (1998). The reliability of the ccrt measure: Results from eight samples. *Understanding transference: The core conflictual relationship theme method*. (2nd ed., pp. 97-108). Washington, DC: American Psychological Association.
- Marcus, D.K. & Buffington-Vollum, J.K. (2005). Countertransference: A social relations perspective. *Psychotherapy Integration, 15*(3), p. 254-283.
- Makari, G. J., & Michels, R. (1993). Transference and countertransference. *Current Opinion in Psychiatry, 6*, 358-361.
- Mayman, M. & Faris, M. (1960). Early memories as expressions of relationship paradigms. *American Journal of Orthopsychiatry, 30*, 507-520.
- McIntyre, S. M. & Schwartz, R. C. (1998). Therapists' differential countertransference reactions toward clients with major depressive or borderline personality disorder. *Journal of Clinical Psychology, 54*(7), 923-931. doi:10.1002/(SICI)1097-4679(199811)54:7<923::AID-JCLP6>3.0.CO;2-F
- Norcross, J. C. (2011). *Psychotherapy relationships that work: Evidence based responsiveness* (2nd ed.). New York, NY: Oxford University Press.

- Peabody, S. A. & Gelso, C. J. (1982). Countertransference and empathy: The complex relationship between two divergent concepts in counseling. *Journal of Counseling Psychology, 29*, 240-245.
- Pincus, D., Freeman, W. & Modell, A. (2007). A neurobiological model of perception: Considerations for transference. *Psychoanalytic Psychology, 24*(4), 623-640. doi: 10.1037/0736-9735.24.4.623
- Racker, H. (1957). The meanings and uses of countertransference. *Psychoanalytic Quarterly, 26*, 303-357.
- Racker, H. (1968). *Transference and countertransference*. New York: International Universities Press.
- Rawl, M. (1958). An experimental study of transference and resistance phenomena in psychoanalytically-oriented psychotherapy. *Journal of Clinical Psychology, 14*, 418.
- Rawl, M. (1981). A note on unwitting replication: Quantitative studies of transference and resistance twenty years apart. *Journal of Clinical Psychology, 37*, 782.
- Robbins. S. B. & Jolkovski, M. P. (1987). Managing countertransference feelings: An interactional model using awareness of feeling and theoretical framework. *Journal of Counseling Psychology, 34*, 276-282.
- Rosenberger, E. W. & Hayes, J. A. (2002). Origins, consequences, and management of countertransference: A case study. *Journal of Counseling Psychology, 11*, 231-250.
- Sandler, J. (1976). Countertransference and role responsiveness. *The International Review of Psychoanalysis, 3*, 43-47.

- Sandler, J. (1987). *Projection, identification, projective identification*. Madison, C.T.: International Universities Press.
- Sandler, J., Dare, C., & Holder, A. (Eds.). (1992). *The Patient and the Analyst*. London: Karnac Books.
- Schacht, T. B., & Binder, J. (1982). *Focusing: A manual for indentifying a circumscribed area of work for time-limited dynamic psychotherapy (TLDP)*. Unpublished manuscript: Vanderbilt University.
- Seitz, P. (1966). The consensus problem in psychoanalytic research. In L. G. A. Auerbach (Ed.), *Methods of rearsch in psychotherapy* (pp. 209-225). New York: Appleton-Century-Crofts.
- Sharkin, B. & Gelso, C. J. (1993). The influence of counselor-trainee anger proneness on reactions to an angry client. *Journal of Counseling and Development*, 71, 483-487.
- Smith, T. L., Barrett, M. S., Benjamin, L. S., & Barber, J. P. (2006). Relationship factors in treating personality disorders. In L. G. Castonguay, & L. E. Beutler (Eds.), *Principles of therapeutic change thta work*. (pp. 219-252). New York, New York: Oxford University Press.
- Spotnitz, H. (1999). *Modern psychoanalysis of the schizophrenic patient: Theory of the technique*. New York, NY: YBK Publishers.
- Strupp, H., Chassan, J. & Ewing, J. (1966). *Toward the longitudinal study of the psychotherapeutic process*. New York: Appleton-Century-Crofts.
- Subotnick, L. (1966a). Transference in child therapy: A third replication. *Psychological Record*, 16, 265-277.

- Subotnick, L. (1966b). Transference in client-centered play therapy. *Psychology* 3, 2-17.
- Sullivan, H. S. (1953a). *Conceptions of modern psychiatry*. New York: Norton.
- Sullivan, H. S. (1953b). *The interpersonal theory of psychiatry*. New York: Norton.
- Teller, V. & Dahl, H. (1981). The framework for a model of psychoanalytic inference. *Proceedings of the Seventh International Joint Conference on Artificial Intelligence*, 1, 394-400.
- Tishby, O. & Vered, M. (2011). Countertransference in the treatment of adolescents and its manifestation in the therapist-patient relationship. *Psychotherapy Research*, 21(6), 621-630. doi:10.1080/10503307.2011.598579
- Tishby, O. & Wiseman, (2014). Types of countertransference dynamics: An exploration of their impact on the client-therapist relationship. *Psychotherapy Research*, 24(3), 360-375. doi: 10.1080/10503307.2014.893068
- Tomkins, S. (1979). *Script theory: Differential magnification of affects*. (Vol. 26). Lincoln: University of Nebraska Press.
- Waldinger, R. J., Seidman, E. L., Gerber, A. J., Liem, J. H., Allen, J. P. & Hauser, S. T. (2003). Attachment and core relationship themes: Wishes for autonomy and closeness in the narratives of securely and attached adults. *Psychotherapy Research*, 13(1), 77-98. doi:10.1093/ptr/kpg008
- Wallerstein, R. (1986). *Forty-two lives in treatment: A study of psychoanalysis and psychotherapy*. New York: Guilford Press.
- Wallerstein, R., Robbins, L, Sargent, H., & Luborsky, L. (1956). The psychotherapy research project of the Menninger Foundation: Rationale, method and sample use. *Bulletin of the Menninger Clinic*, 20, 221-280.

Wampold, B. (2001). *The great psychotherapy debate: Models, methods, and findings.*

Mahway, NJ: Erlbaum Publishers.

Weiss, J., Sampson, H., & The Mount Zion Psychotherapy Research Group (1986). *The*

psychoanalytic process: Theory, clinical observations, and empirical research.

New York: Guilford Press.

Winnicott, D. W. (1949). Hate in the countertransference. *The International Journal of*

Psychoanalysis, 30, 69-74.

Wiseman, H., Tishby, O. (2014) Types of countertransference dynamics: an exploration

of their impact on client-therapist relationship. *Psychotherapy Research*, 20(24).

360-375.

Appendix A. Therapist Recruitment Letter

Therapist Informed Consent Form

Patient Recruitment Letter

Therapist Informed Consent Form

Recruitment for Research Study



Dear potential participant,

Please review the following email and if interested, please contact the principal investigator, Matthew Johnson, at mcj133@psu.edu

The purpose of this research study is to explore a coding system that examines therapist reactions. The study itself is being done for research purposes with the hope that it will advance what we as researchers and clinicians know about therapist reactions.

To be considered for this study you will need to be a therapist in training at CAPS who sees at minimum eight patients on any given week. If selected, you will meet with the principal investigator. During the meeting you will fill out all appropriate consent forms and then talk about your life experiences in an interview format. Upon completion of the interview, a receptionist at CAPS will hand out consent forms to your patients before your first therapy session until five of them sign consent forms. After each one consents, you will take an audio-recording device into the first five to seven sessions for recording purposes. After each session, you will be asked to fill out a questionnaire regarding your feelings during the session. The questionnaire will take approximately 3-5 minutes.

At the end of the study, you will receive a \$100 payment for your participation. The payment will be made in cash, so that there is no issue with banks, etc.

If you have read and understand the above statements, and would like to be considered for participation, please contact the principal investigator, Matthew Johnson at mcj133@psu.edu.

INFORMED CONSENT FORM



ORP OFFICE USE ONLY
DO NOT REMOVE OR MODIFY
IRB#42986 Doc. #1001
 The Pennsylvania State University
 Institutional Review Board
 Office for Research Protections
 Approval Date: 07/12/2013- PCF
 Expiration Date: 07/11/2014- PCF

Title of Project: Using the Core Conflictual Relationship Theme (CCRT) Method as a Countertransference Coding Technique.

Principal Investigator: Matthew Johnson, Graduate Student
 University Park, PA 16802
 (347) 308-4551; mcj133@psu.edu

Advisor: Dr. Jeffrey Hayes
 306 CEDAR Building
 University Park, PA 16802
 (814) 863-3799; jxh34@psu.edu

Purpose of the Study: The purpose of this research study is to explore a coding system that examines therapist reactions.

Procedures to be followed: You will be asked to interview with the principal investigator for approximately one hour. During the interview you will fill out the proper consent forms and then talk about your life experiences. Upon completion of the interview, you will be asked to complete IRB training and to recruit as many as five patients from your caseload. You will then audio record your sessions with the five participating patients/clients for 5-7 sessions. Upon the completion of each recorded session you will fill out a questionnaire that will take approximately five minutes.

Discomforts and Risks: There are no risks in participating in this research beyond those experienced in everyday life. Some of the questions are personal and might cause discomfort.

Benefits: You may be able to reflect on your life experiences during the interview. For some participants, such an experience may be meaningful.

Duration: It will take approximately 50-70 minutes to complete the interview and approximately five minutes after every session to fill out a questionnaire.

Statement of Confidentiality: Your participation in this research is confidential. The data will be stored and secured at CAPS in a locked file. The Pennsylvania State University's Office for Research Protections, the Institutional Review Board and the Office for Human Research Protections in the Department of Health and Human Services may review records related to this research study. In the event of a publication or presentation resulting from the research, no personally identifiable information will be shared.

Per Pennsylvania State law, participants must be given a choice as to whether they wish to have their information recorded and kept. As such, please sign whether or not you allow records to be obtained and kept for research purposes.

Participant Signature Date

Person Obtaining Consent Date

Right to Ask Questions: Please contact Matthew Johnson at (347) 308-4551 with questions, complaints or concerns about this research. You can also call this number if you feel this study has harmed you. If you have any questions, concerns, or problems regarding your rights as a research participant or would like to offer input, please contact The Pennsylvania State University's Office for Research Protections (ORP) at (814) 865-1775. The ORP cannot answer questions about research procedures. Questions about research procedures can be answered by the research team.

Payment for participation: The participating therapist will receive a \$100.00 payment at the completion of this study.

Voluntary Participation: Your decision to be in this research is voluntary. You can stop at any time. You do not have to answer any questions you do not want to answer. Refusal to take part in or withdrawing from this study will involve no penalty or loss of benefits you would receive otherwise.

You must be 18 years of age or older to take part in this research study. If you agree to take part in this research study and the information outlined above, please sign your name and indicate the date below.

You will be given a copy of this consent form for your records.

Participant Signature Date

Person Obtaining Consent

Client Recruitment for Research Study



Dear potential participant,

Please review the following email about a potential research study you could participate in. If you would like to be involved, or have any questions or concerns, please contact the principal investigator, Matthew Johnson, M.A. at mcj133@psu.edu.

The purpose of this research study is to explore a coding system that examines therapist reactions. To do this effectively, we need to look at real-time therapy sessions. Thus, this particular study is being done for research purposes with the hope that it will advance what we as researchers and clinicians know about therapist reactions.

To be considered for this study you will need to be a client who is seeking treatment at CAPS who is over the age of 18 years old and has consented for his or her demographic treatment information to be used and his/her therapy sessions recorded, transcribed, and coded. After you consent to release your demographic information and for your treatment sessions to be recorded, transcribed, and coded, nothing else will be asked of you. Additionally, it should be noted that the principal investigator of this study is the only one who will have access to your identifying information during transcription. Additionally, during the transcription process the principal investigator will modify/change all identifying information within the transcripts to further protect your confidentiality.

If you have read and understand the above statements, and would like to be part of the research study, please contact the principal investigator, Matthew Johnson, at mcj133@psu.edu. He will then meet you at the beginning of your first session to sign the proper procedural consents. No further action is required by you after the initial consents are signed and you will receive up to \$75.00 upon completion of your 3-5 therapy sessions. The consenting process should take no longer than five minutes of your time. If you are unsure, but might still be interested in being considered for participation, please contact the principal investigator, Matthew Johnson at mcj133@psu.edu so that he may answer any questions or concerns you might have.

CLIENT CONSENT FORM



ORP OFFICE USE ONLY
DO NOT REMOVE OR MODIFY
IRB#42986 Doc. #1002
 The Pennsylvania State University
 Institutional Review Board
 Office for Research Protections
 Approval Date: 11/15/2013- PCF
 Expiration Date: 07/11/2014- PCF

Title of Project: Using the Core Conflictual Relationship Theme (CCRT) Method as a Countertransference Coding Technique.

Principal Investigator: Matthew Johnson, Graduate Student
 University Park, PA 16802
 (347) 308-4551; mcj133@psu.edu

Advisor: Dr. Jeffrey Hayes
 306 CEDAR Building
 University Park, PA 16802
 (814) 863-3799; jxh34@psu.edu

Purpose of the Study: The purpose of this research study is to explore a coding system that examines therapist reactions.

Procedures to be followed: You are being asked to consent to have all of your therapy sessions recorded, transcribed, and coded. Upon consent your sessions will be audio-recorded by your therapist. Your therapy sessions will then be transcribed by the principal investigator. The principal investigator will attempt to de-identify any information within the transcriptions before handing them over to a coding team.

Discomforts and Risks: Due to the fact that you will be discussing personal information, you may experience discomfort during the therapy session. In addition, there is the risk of loss of confidentiality of the data. Should the health information be disclosed by the researcher, to someone outside of this study, it may no longer be covered/protected by the federal regulation HIPAA. However, it should be noted that you are not being asked to do anything beyond giving your consent for your sessions to be audio recorded, transcribed, and coded.

Compensation: After you complete your 3-5 therapy sessions at CAPS, you will be sent a check for \$75.00 for your participation in the study.

3 sessions - 35.00

4 sessions - 50.00

5 sessions - 75.00

Benefits: This study may aid the advancement of scientific knowledge within the field of psychotherapy.

Duration: Upon giving your consent, no further action will be required other than your persistent and consistent attendance in therapy. Every therapy session lasts approximately 50 minutes. Your 50-minute sessions will be recorded for approximately 5-7 sessions.

Statement of Confidentiality: It should be noted that demographic, psychological, and health information about you will be collected because you are a part of this research study. By signing this form, you are allowing the people and groups that are listed in the next paragraph to use your health information, but only to use it within this research. You are also allowing these groups to share your health information with other specific groups for their use within this research study. Your information will only be used as explained in this consent form or when required by law. The research information not already in your medical record will be destroyed six years after the completion of this study as required by HIPPA regulations. Any research information in your medical record will be kept indefinitely.

- The research team may use the following sources of health information:
Demographic and psychological diagnosis, psychological intakes, and psychotherapy sessions.

Research records that identify you will be kept confidential as required by law. You will not be identified by name, social security number, address, phone number or any other direct personal identifier in research records given to someone outside of The Pennsylvania State University (PSU), except when required by law. For records shared outside of PSU, you will be assigned a code number. The list that matches your name with the code number will be kept in a locked file in a CEDAR Psychological Building office. Again, your participation in this research is confidential. The data will be stored and secured at CEDAR Building in a locked file. The Pennsylvania State University's Office for Research Protections, the Institutional Review Board and the Office for Human Research Protections in the Department of Health and Human Services may review records related to this research study. In the event of a publication or presentation resulting from the research, no personally identifiable information will be shared.

Per Pennsylvania State law, participants must be given a choice as to whether they wish to have their information recorded and kept. As such, please sign whether or not you allow records to be obtained and kept for research purposes. If you wish to participate in this research, you must sign this form. If you do not wish to participate, and do not sign the form, you will still receive the standard psychological care as decided by your therapist.

Participant Signature

Date

Person Obtaining Consent

Date

Right to Ask Questions: Please contact Matthew Johnson at (347) 308-4551 with questions, complaints or concerns about this research. You can also call this number if you

feel this study has harmed you. If you have any questions, concerns, or problems regarding your rights as a research participant or would like to offer input, please contact The Pennsylvania State University's Office for Research Protections (ORP) at (814) 865-1775. The ORP cannot answer questions about research procedures. Questions about research procedures can be answered by the research team.

Voluntary Participation: You are free to withdraw your permission for the use and sharing of your health information, but you must do this in writing as indicated in the PSU Privacy Notice. If you decide to withdraw, we ask that you contact P.I. Matthew Johnson in writing and let him know that you are withdrawing from the research study. His email address is mcj133@psu.edu. If you withdraw your permission, we will no longer use or share medication information about you for the reasons covered by your written authorization, except when the allows us to continue using your information. We are unable to take back anything we have already done or shared with your permission, and we are required to keep our records of what we provided to you until 8/31/2019.

You must be 18 years of age or older to take part in this research study. If you agree to take part in this research study and the information outlined above, please sign your name and indicate the date below.

You will be given a copy of this consent form for your records.

Participant Signature

Date

Person Obtaining Consent

Date

Appendix B. Clustered List of CCRT Components: Wishes

Clustered List of CCRT Components: Responses from Other

Clustered List of CCRT Components: Responses to Self

Appendix C. Relationship Episode (RE) Completion Scale

Appendix C

Completeness Ratings of Hypothetical Relationship Episodes

Rating	Essence of the Relationship Episode
1.0	I met Joe and we talked. (No CCRT components)
1.5	I met Joe and we talked and he said little. (A fairly vague response from other)
2.0	I met Joe, we talked and he said little. He's an old friend from school who I like. (More vague components, a hint of a wish and a response of self)
2.5	I met Joe, we talked, he said little. He's an old friend from school who I like. I was disappointed he said so little about the event we went through together. (Enough information to score a wish, response from other, and response of self)
3.0	(Beyond the 2.5 level, the completeness ratings are based on how much the patient elaborates on the story and how detailed the information for each of the components is.)
3.5	
4.0	I met Joe, we talked, he said little. He's an old friend from school who I like. I was disappointed he said so little about the event we went through together. I was kind of trying to relive those days and get back the feeling of that event we shared, but Joe seemed distracted. I suggested we meet for lunch next week and he agreed. (All three components are more detailed and more explicit)
4.5	(Like the 4.0 description above, but with even more detail)
5.0	(Like the 4.5 description above, but with even more detail)

*Appendix C is taken directly from Luborsky and Crits-Christoph (1998) seminal book, *Understanding Transference: The Core Conflictual Relationship Theme Method* (p. 20).

Vita

Matthew C. Johnson

420 London Street • Portsmouth, VA 23704 • 347-308-4551 • mcj133@psu.edu

EDUCATION

Ph.D., Counseling Psychology (APA-Accredited) August 2015

The Pennsylvania State University, University Park, PA

Dissertation: Measuring Countertransference Responses in Therapists towards Clients Using the Core Conflictual Relationship Theme Measure

M.A., Modern Psychoanalysis April 2008

Boston Graduate School of Psychoanalysis, Brookline, MA

B.A., Psychology, Minors: Philosophy, English May 2005

Temple University, Philadelphia, PA

RESEARCH EXPERIENCE

The Pennsylvania State University, University Park, PA August 2009 – August 2015

College of Education

Primary Investigator

- Conducted objective research that generated independent, high quality, and reproducible results in a scientific and ethical manner
- Trained and provided continuous training to a team of coders who carried out an intricate interpersonal coding procedure known as the Core Conflictual Relationship Theme (CCRT) coding method
- Prepared and submitted scientific protocols to Pennsylvania State University's Institutional Review Board
- Was responsible for the management and integrity of the design, conduct, and ethical reporting of the research project's findings

The Pennsylvania State University, University Park, PA August 2009 – August 2012

Center for Collegiate Mental Health

Graduate Assistant

- Was member of a research team which analyzed, presented, and published data from a large, national sample of students seeking mental health services at college counseling centers
- Met bi-weekly with the research team and to discuss a myriad of topics including, but not limited to, collegiate mental health, utilization of campus psychological services, substance abuse, and atypical college populations