TRAINEES’ ABILITY TO MANAGE COUNTERTRANSFERENCE:
AN EXPLORATION OF EMOTIONAL INTELLIGENCE
AND COUNSELOR SELF-EFFICACY

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by
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ABSTRACT

Prior to this study, research had established the importance of acknowledging and understanding how countertransference may negatively impact therapeutic work (Ligiero & Gelso, 2001; Rosenberger & Hayes, 2002). While not all countertransference reactions are problematic, these reactions can often create distance in the relationship if they are acted upon. Gelso and Hayes (2007) have suggested that managing countertransference behaviors is possible when utilizing the five therapist characteristics which aid in managing these reactions: self-insight, conceptualization skills, empathy, self-integration, and anxiety management skills. This study’s aim was to examine possible variables which may positively impact the therapist characteristics so as to increase one’s ability to manage countertransference. Counselor self-efficacy and emotional intelligence were identified as possible means of doing so. There were two hypotheses tested in this study: (1) counselor self-efficacy and (2) emotional intelligence would be directly related to the ability to manage countertransference reactions. Overall a small but significant relationship between countertransference management and counseling self-efficacy was detected, suggesting that as a trainee’s belief about his or her ability to be effective in therapy and with helping skills increases, so does his or her ability to manage countertransference reactions. Emotional Intelligence and countertransference management were not significantly related. Further analyses revealed several notable correlations between countertransference management and the independent variables. These findings will be reviewed along with limitations of this study and implications for supervision practices in the future.
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Chapter I

Introduction

A significant body of literature exists establishing the inevitability of countertransference reactions of therapists, as well as the adverse effects which may result (Gelso & Hayes, 2007). Research has shown that countertransference reactions are the result of past or present unresolved conflicts and vulnerabilities (Gelso & Hayes, 2007). They may result in a deterioration of the therapeutic alliance as the therapist withdraws, avoids, or becomes overly-involved in the patient material (Cutler, 1958; Fauth & Hayes, 2006; Gelso, Fassinger, Gomez, & Latts, 1995; McClure & Hodge, 1987; Myers & Hayes, 2006; Rosenberger & Hayes, 2002). For these reasons, managing these reactions is vital to the progress of therapy. While countertransference reactions may be inevitable, Gelso and Hayes (2007) theorize that there are five therapist characteristics which aid in managing these reactions: self-insight, conceptualization skills, empathy, self-integration, and anxiety management skills. The purpose of this study will be to examine how emotional intelligence and counselor self-efficacy (CSE) impact one’s ability to manage countertransference reactions. It is hypothesized that as emotional intelligence and CSE increase, so will one’s ability to manage countertransference reactions.

Countertransference

The role of countertransference in psychotherapy has proven to be somewhat troublesome as several definitions and its function have been debated. Countertransference may be viewed as both an aid and hindrance in treatment (Gelso & Hayes, 2007). Freud (1910) believed that countertransference was something to recognize
and overcome, as it only hindered the understanding and treatment of the patient. In recent decades, a shift in conceptualizations of countertransference has been to consider it potentially helpful when managed effectively (Peabody & Gelso, 1982). This helpfulness depends, however, on how the therapist uses internal countertransference reactions. If the countertransference is used to understand the patient it may be beneficial. For example, Gorkin (1987) posited that revealing countertransference feelings to patients conveys a sense of reality that the therapist is honest and genuine, and may even be helpful during a negative therapeutic experience. However, if these feelings are acted out in session they are potentially harmful (Gelso & Hayes, 2007). The present study defines countertransference using Gelso and Hayes’ integrative definition which views countertransference as a therapist’s internal and external reactions which are rooted in unresolved conflicts (Gelso & Carter, 1985; Gelso & Hayes, 1998).

Empirical evidence has found that therapists’ countertransference reactions are associated with misperceptions of patients (McClure & Hodge, 1987), therapist anxiety (Hayes & Gelso, 1991, 1993), poorer working alliance as judged by supervisors and doctoral trainees (Ligiero & Gelso, 2001), and avoidant therapist behavior (Hayes et al., 1998; Rosenberger & Hayes, 2002; Robbins & Jolkovski, 1987; Yulis & Kiesler, 1968). This demonstrates the importance of examining one’s own reactions and behaviors with patients. Hayes (1995) proposed a conceptual model of countertransference which deconstructs it into five elements: origins, triggers, manifestations, effects, and, the focus of this study, management of countertransference.
Countertransference Management

Countertransference management is a therapist’s ability to control his or her reactions to patients while minimizing the negative impact they have on the therapeutic process (Gelso & Hayes, 2001). Gelso and Hayes (2007) theorize there are five therapist characteristics which aid in managing countertransference: self-insight, conceptualizing skills, empathy, self-integration, and anxiety management skills.

*Self-insight* refers to the extent which a therapist is aware of and understands the basis of his or her own feelings, which may include countertransference feelings. A study by Baehr (2004) of 12 psychologists’ countertransference management found that therapists described being less self-aware when they were run-down or burnt out. These therapists named free-floating reflection, meditation, and self-care as means of promoting their self-awareness (Baehr, 2004). *Conceptualizing ability* describes a therapist’s ability to use a theoretical perspective to understand a patient within the therapeutic relationship. Two studies have found that therapists were less likely to display their countertransference behavior when they were aware of their feelings and had a theoretical framework to understand their reactions to patients (Latts & Gelso, 1995; Robbins & Jolkovski, 1987). *Empathic ability* allows a therapist to identify with the patient and focus on the patient’s needs in session despite many of the therapist’s own circumstances. Research has found that empathic ability is negatively correlated with countertransference behavior (Peabody & Gelso, 1982), and that awareness of countertransference feelings in trainees along with the use of a theory, fostered appropriate countertransference management (Latts & Gelso, 1995; Robbins & Jolkovski, 1987). *Self-integration* is defined as a therapist’s basically healthy character structure and
overall well-being which allows him or her to recognize ego boundaries while being appropriately differentiated. Countertransference arises from unresolved conflict within the therapist and can interfere with the therapeutic process and outcome (Hayes & Gelso, 1993; Hayes et al., 1998; Hayes, Riker, & Ingram, 1997; Ligiero & Gelso, 2002; Rosenberger & Hayes, 2002). Lastly, *anxiety management* is the ability of a therapist to experience and recognize anxiety while possessing the internal skill to control and understand the anxiety so it does not affect the therapeutic relationship negatively. Several studies have identified both state and trait anxiety as predictors of countertransference behavior (Gelso et al., 1995; Hayes et al., 1998; Hayes & Gelso, 1991, 1993; Yulis & Kiesler, 1968). Therapists who are better able to manage their anxiety are less likely to display countertransference behavior (Fauth & Williams, 2005; Gelso et al., 1995; Gelso, Latts, Gomez, & Fassinger 2002; Hayes & Gelso, 1991; Yulis & Kiesler, 1968).

*Emotional Intelligence*

Research suggests that many aspects of emotional intelligence, such as awareness of one’s own and others’ emotions, and the regulation of both one’s own and others’ emotions, are essential to therapeutic work (Louie, Coverdale, & Roberts, 2006). Emotions are thought to also contribute unique information about the surrounding environment which in turn, informs subsequent thoughts, actions, and feelings (Salovey, Bedell, Detweiler, & Mayer, 2000). According to Mayer and Salovey (1997), emotions can both inform and promote our intelligence through processes such as reflective regulation of emotion, understanding and analyzing emotions, emotional facilitation of thought, and the perception, appraisal, and expression of emotion. In fact, these qualities
constitute the four-branch ability model of emotional intelligence. Research examining emotional intelligence indicates that it may benefit the training of psychologists and counselors as it is correlated with effective coping strategies (Austin, Saklofske, & Egan 2004; Brackett, Mayer, & Warner., 2004; Lopes et al., 2004; Louie et al., 2006), and psychological well-being (Ciarrochi & Godsell, 2006; Gohm, 2003; Gohm, Baumann, & Siezek., 2001; Gohm & Clore, 2002). Emotional intelligence also appears to be moderately correlated with empathy (Brackett, Rivers, Shiffman, Lerner, & Salovey, 2006; Caruso, Mayer, & Salovey, 2002; Ciarrochi, Chan, & Caputi, 2000; Mayer, Caruso, & Salovey, 2000; Schutte, Malouff, Thorsteinsson, Bhullar, & Rooke, 1998). It is hypothesized that therapists and counselors who have higher emotional intelligence will be able to understand and accurately perceive emotion with their patients better than those with lower emotional intelligence.

Counselor Self-Efficacy

Another construct which theoretically appears to be related to the five components of countertransference management is CSE. CSE was adapted from Bandura’s theory of self-efficacy which is embedded in Bandura’s Social Cognitive Theory. Bandura (1994) states that self-efficacy is influenced by the person, his or her behavior, and the surrounding environment. Self-efficacy determines how fervently someone will aspire to and pursue a goal and how much effort will be used; it will also shape the expected outcome (Bandura, 2004). It is both directly and indirectly an influence on behavior, goal beliefs, outcome expectations of behavior, and how the environmental factors are viewed (Bandura, 2004). Bandura states that people with low self-efficacy tend to focus on personal inadequacies, anticipate problematic
circumstances, and over-exaggerate difficulties, while individuals with high self-efficacy tend to invest greater effort and motivation to complete difficult tasks (Bandura, 1982).

CSE is defined by Larson and Daniels (1998) as the beliefs one holds about his or her ability to effectively counsel patients. The literature exploring CSE has yielded findings such that as self-efficacy increases so does a counselor’s ability to perform counseling skills (Larson, Clark, Wesely, Koraleski, Daniels, & Smith, 1999; Larson, Suzuki, Gillespie, Potenza, Bechtel, & Toulouse, 1992; Lent, Hill, & Hoffman, 2003; Nutt Williams, Judge, Hill, & Hoffman, 1997). Similarly, anxiety decreases among counselors in training as counselor self-efficacy increases (Johnson, Baker, Kopala, Kiselica, & Thompson 1989; Larson et al., 1992; Larson et al., 1999; Lent et al., 2003; Margolies, Wachtyel, & Schmelkin, 1986; Nutt Williams et al., 1997). Studies have also show that as trainees gain experience, CSE also increases (Melchert Hays, Wiljanen, & Kolocerk, 1996; Sipps, Sugden, & Favie, 1988). Many of the scales which measure CSE, such as the Counseling Self Estimate Inventory (Larson et al., 1992) and the Counselor Activity Self-Efficacy Scales (Lent et al., 2003), have included items which examine reactions and behaviors which may impact a counselor’s ability to work with patients. These items highlight the importance of countertransference management in effectively counseling patients.

The purpose of the current study is to examine how emotional intelligence and CSE are related to managing countertransference in counselors and psychologists in training. It was hypothesized that there will be a direct relation between emotional intelligence and countertransference management such that as emotional intelligence increases, so will countertransference management. There is also expected to be a direct
relation between CSE and countertransference management such that as CSE increases, so will countertransference management.
Chapter II

“The therapist himself, his background, attitudes, experiences, and personality must be put under the microscope for careful scrutiny and analysis if valid knowledge about how to treat mental illness is to be obtained” (Strupp, 1958, p. 34)

Research indicates that the therapist’s personal characteristics are an integral part of the therapeutic relationship and therapy outcome (Beutler & Harwood, 2000; Norcross, 2001; Orlinsky, Grawe, & Parks, 1994; Wampold, 2001). Norcross (2002) has argued that effective therapeutic relationships cannot be boiled down to specific techniques or theories; the human element cannot be removed from the therapeutic relationship. However, the effects of the therapist’s personality and interpersonal qualities on psychotherapy have been called the “neglected variable” (Garfield, 1997) of psychotherapy research, perhaps because of the complexity in examining them.

The use of the therapist’s self as a therapeutic tool can be greatly influenced by previous experiences as well as current feelings and cognitions. What also impacts the functioning of the therapeutic tool are unresolved inner conflicts and vulnerabilities which are exposed during the intimate work of psychotherapy. These countertransference reactions can provide insight to the therapist about the relationship with a particular patient and help cultivate an empathic connection with the patient (Gelso & Hayes, 2007). However, these reactions may also impair therapeutic work via defensive reactions to patients’ material, acting in a manner which fulfills the therapist’s own needs, perceiving patients in a distorted fashion, and exhibiting poor clinical judgment (Hayes et al., 1998). According to findings from Hayes et al. (1998), countertransference feelings are experienced in as many as 80% of psychotherapy sessions. Therefore, it is
critical to study therapist characteristics which aid in managing countertransference reactions, as theory and research suggest that when countertransference is not controlled (and not examined), it can adversely affect the therapeutic relationship (Gelso & Hayes, 2007). The present study will examine ways to cultivate countertransference management. Specifically, therapists’ emotional intelligence (EI) and self-efficacy (SE) will be studied in their capacity to enhance one’s ability to manage countertransference-based affect, thoughts, and behaviors.

*Defining Countertransference*

Before the management of countertransference can be examined, countertransference must be defined. This can be a somewhat cumbersome task, as several definitions have emerged in the literature, especially as other theories besides psychoanalysis have recognized the prevalence and importance of understanding countertransference. Freud believed it was more than advantageous for the analyst to pay attention to his or her own unconscious reactions within the context of the therapeutic relationship because by studying one’s own unconscious mind and understanding the self, the therapist might better understand the inner workings of the patient (Freud, 1910). However, Freud’s definition of countertransference (the classical view described in the next section) implies that it can only injure the therapeutic relationship, and therefore must be eliminated via self-analysis. Freud advised psychoanalysts to model themselves after surgeons who solely focus on performing as skillfully as possible and thereby abandoning their feelings and even human sympathy.

We have begun to consider the “counter-transference,” which arises in the physician as a result of the patient’s influence on his [the physician’s]
unconscious feelings, and have nearly come to the point of requiring the physician to recognize and overcome his counter-transference in himself…we have noticed that every analyst’s achievement is limited by what his own complexes and resistances permit (Freud, 1910/1959, p.289).

In subsequent decades, a shift in the definition of countertransference occurred to include elements which explain how not all aspects of countertransference lead to negative outcomes. In their recent work, Gelso and Hayes (2007) outline three conceptualizations of countertransference.

**Classical view.** As first conceptualized by Freud, the classical definition of countertransference encompasses the unconscious, neurotic, conflict-based reactions to a patient’s transference which are based in the therapist’s childhood unresolved conflicts and are triggered during the therapeutic process (Freud, 1910/1959). Countertransference can lead the therapist to have distorted perceptions of symptoms and behaviors of the patient which may create difficulty in understanding the underlying issues of the patient and working productively (Hayes, 2004b). From the classical perspective, countertransference is to be avoided whenever possible. Many researchers in the field consider this definition as too restrictive (Epstein & Feiner, 1979; Fauth & Hayes, 2006; Gelso & Hayes, 1998, 2002, 2007).

**Totalistic view.** The totalistic view of countertransference includes all attitudes, feelings, identifications, and reactions toward the patient (Gelso & Hayes, 2007; Kernberg, 1975). Within this definition, it is assumed that therapists will examine their internal and external reactions to patients and use these data to inform their work with patients. The therapist’s internal reactions are important because they show how others
may react to this patient and clarify the patient’s transference. However, this definition is too all-encompassing; with every reaction being considered countertransference, there is no need for this specific term to identify a therapist’s emotional reactions (Gelso & Hayes, 2007).

_Complementary view._ The complementary definition of countertransference views reactions as complementary to the transference of the patient (Epstein & Feiner, 1988). Along with the totalistic view, this definition holds that the therapist’s internal reactions are often inevitable and a result of the patient’s way of relating. Unlike the totalistic view, this definition emphasizes the “pull” of the patient on the therapist, and the therapist’s impulse to respond (Kiesler, 1996, 2001). While this definition captures the interpersonal aspect of countertransference better than the other definitions, it does not account for the therapist’s unresolved material as a cause for the countertransference (Gelso & Hayes, 2007). Rather, it focuses attention on the patient’s pathology and defenses, without regard for what the therapist brings to the therapeutic relationship.

*Integrative View of Countertransference*

Rather than strictly adhering to any one of these definitions of countertransference, Gelso and Hayes (2007) posit their own integrative conception of countertransference which contains elements of all three previously reviewed conceptions, while adding new components. Specifically, for the purpose of this paper, countertransference will be conceptualized and defined consistent with this theory. Countertransference is defined as “the therapist’s internal or external reactions that are shaped by the therapist’s past or present emotional conflicts and vulnerabilities” (Gelso &
Hayes, 2007, p. 25). In order to understand the integrative nature of this theory, each element of this definition requires clarification.

First, in order for the therapist’s reactions to be considered countertransference, the conflict must arise from an unresolved issue or vulnerability within the therapist. Triggers of the countertransference are usually a subtle or overt behavior of the patient. “Countertransference requires a ‘hook’ in the therapist, so to speak, a soft spot that the patient’s affects stimulate” (Gelso & Hayes, 2007, p. 28). Countertransference can result from issues with one’s family of origin, narcissism, roles in romantic relationships and families, unmet needs, and professional roles (Gelso & Hayes, 2007). Other examples of unresolved conflicts which may impact a therapist’s work with patients include homophobia (Hayes, et al., 1998) or fears of intimacy and unresolved issues with loss (Boyer & Hoffman, 1993). An important distinction is that not any and all therapist reactions are countertransference and not all countertransference reactions are negative or unhelpful. Indeed, Gorkin (1987) posited that revealing countertransference feelings to patients may be helpful by conveying a sense of reality that the therapist is honest and genuine. However, Myers and Hayes (2006) found that when the working alliance was perceived to be strong, countertransference disclosures caused the session to be viewed as shallow and the therapist to appear less of an expert. From this study, it appears that when a disclosure is too personal or reveals the unresolved issues of the therapist, it may negatively impact the patient’s view of the therapist.

A second part of the integrative view of countertransference includes the past or present nature of the conflict within the therapist. Vulnerabilities may be from historical experiences which have been stored in the unconscious and are triggered by the patient’s
related experience or a given behavior. Conflicts and vulnerabilities may also result from present issues which the therapist is currently experiencing (Gelso & Hayes, 2007).

A third portion of the definition of countertransference involves either internal or external reactions of the therapist. Internal reactions would include thoughts, emotions, or bodily sensations, while external reactions include verbal and nonverbal behavior. Being mindful of one’s internal countertransference reactions to patients is an important part of understanding the conflict, appropriately responding to the patient’s needs, and being responsive to the feelings which the patient’s actions generate. As therapists, we are always vulnerable to the patient’s material in session. This vulnerability can be positive in that it allows therapists to empathically connect with their patients, responding to the patient’s feelings, rather than avoiding them (Latts & Gelso, 1995; Peabody & Gelso, 1982; Robbins & Jolkovski, 1987). An integrative perspective of countertransference implies that the therapist must examine his or her own reactions and behaviors with patients, especially when something feels awry in the relationship with the patient (Gelso & Hayes, 2007).

The Structural Elements of Countertransference

With a conceptual definition of countertransference in mind, the structural elements of countertransference can be examined. These include the origins, triggers, manifestations, effects, and, the focus of this study, management of countertransference.

Origins are unresolved conflicts and vulnerabilities that give rise to countertransference reactions (Gelso & Hayes 2007; Hayes, 2004a). Often the origins can be traced back to issues in childhood and the roots are not always obvious to the therapist. The origins are often multilayered and may include material from the
therapist’s childhood as well as current conflicts and vulnerabilities. For example, a recent traumatic loss which has yet to be resolved may result in countertransference feelings and/or behaviors. Rather than strictly viewing these countertransference reactions as linked to the past, Gelso and Hayes (2007) suggest that pain is part of the human condition, although the loss may be exacerbated by childhood events.

Triggers are the “therapy-related events that touch on therapists’ unresolved conflicts and generate countertransference reactions” (Hayes, 2004a, p. 28). When examined together, origins and triggers are the cause of countertransference. This is called the countertransference interaction hypothesis (Gelso & Hayes, 2007) which follows the totalistic definition of countertransference. The interaction hypothesis states that the conflict is constructed by both the patient and the therapist. To understand countertransference, it is not enough to know the origin of the therapist’s triggers. One must also understand how those triggers are provoked by working with certain patients and in given situations (Hayes, 2004a). Research by Hayes and colleagues into triggers of countertransference has found that there are few consistent answers. Much of the research has focused on the patient’s presenting problems (e.g., rape, HIV infection) and presenting styles (e.g., hostility, dependency, seductiveness). For example, sexual orientation alone is not a consistent trigger of countertransference behavior. Rather, when a therapist’s homophobia is considered, it was found that more homophobic therapists showed greater amounts of countertransference in reaction to gay and lesbian patients (Gelso, et al., 1995; Hayes & Gelso, 1993). That is, countertransference greatly depends on the therapist’s vulnerabilities in addition to the patient’s triggering behavior or attribute.
The third component in the structure of countertransference is manifestations: how countertransference shows itself. Gelso and Hayes (2007) state that there are three forms of countertransference manifestations: affects, behaviors, and cognitions. While none of these in and of themselves indicate countertransference, they should serve as a warning to the therapist to question his or her reactions. Specifically, therapist anxiety should be examined in detail to determine where and how it may be affecting the therapeutic relationship and countertransference reactions. Anxiety appears to be the most common feeling experienced by therapists experiencing conflicts with a patient’s material (Gelso & Hayes, 2007). Freud recognized anxiety as being a reaction to danger and is an example of the ego’s defense to withdraw or avoid from the given situation (1910/1959). Bandura (1956) noted that when a patient expresses tendencies which threaten a therapist, anxiety-laden behavior is the result. While anxiety has been established in the empirical literature as being a predictor of countertransference (Gelso et al., 1995; Hayes & Gelso, 1991, 1993; Yulis & Keisler, 1968), Hayes and colleagues (1998) have also found that other affective states may be indicative of countertransference. Among eight experienced therapists they studied, a majority of therapists felt angry, bored, sad, nurturing, or inadequate in as many as half their sessions (Hayes et al., 1998).

The behavioral manifestations of therapists’ countertransference may include therapists’ avoidance of, withdrawal from, under-involvement, or over-involvement in the patient’s material. Bandura (1956) noted, “therapist-initiated interruptions in the form of questions that serve to drive the discussion, premature interpretations that block the patient’s expressions, paraphrasing the patient’s statements without essential
clarification…” are all reactions which impede the progress of psychotherapy and are the result of anxiety-laden affective states (p. 333). Again, while not any one of these actions necessarily indicates countertransference, the reason why the therapist enacts these behaviors is of interest. In a study by McClure and Hodge (1987), a significant relationship was found between a therapist’s feelings of like or dislike for his/her patients, and countertransference behavior. When the therapist had strong feelings of liking the patient, patients were misperceived as having overly similar personalities to the therapist. When therapists strongly disliked their patients, therapists tended to misperceive their patients as overly dissimilar from themselves. In another study, Cutler (1958) found that when therapists’ unresolved issues were brought up by patients, these therapists tended to misperceive the frequency of how often this material was discussed. In their review of the literature, Hayes and Gelso (2001) found that distortions were at the heart of countertransference. They tentatively concluded that therapists were more likely to under or overestimate the frequency with which patients talked about certain material if it was related to countertransference origins. Similarly, in a study by Fauth and Hayes (2006), counselors’ stress appraisals were measured to determine if there was a relation between countertransference origins and the resulting affective manifestations (stress) and behaviors. The investigators had counselors respond to a videotaped vignette of either a traditional or nontraditional male patient. It was found that stress appraisals did predict countertransference behavior such that negative appraisals were linked to more distant and hesitant counselor behavior while positive appraisals were related to positive evaluations of the patient. Overall, countertransference cognitions, affect, and behaviors are exhibited when a therapist’s unresolved conflicts are brought up in session by the
patient (Fauth & Hayes, 2006; Gelso et al., 1995; Hayes & Gelso, 1991, 1993; Rosenberger & Hayes, 2002).

Other studies of countertransference behavior have found a gender difference such that female therapists tend to over involve themselves when their unresolved conflicts are brought up in therapy, which risks enmeshment with the patient. While male therapists, by contrast, pull away when unresolved conflicts are stimulated (Fauth & Hayes, 2006; Hayes & Gelso, 1991; Peabody & Gelso, 1982; Rosenberger & Hayes, 2002; Williams et al., 1997). It appears that an over-identification with the patient may be a result of “empathic attunement” (Gelso & Hayes, 2007) in which the therapist’s unresolved issues are brought into the forefront and entangled with the patient’s issue. Overall, it appears that avoidant reactions are the most frequently cited behavioral countertransference reactions in the empirical literature (Cutler, 1958; Gelso et al., 1995; Latts & Gelso, 1995; Robbins & Jalkovski, 1987; Yulis & Kiesler, 1968). Avoidant behaviors include changing topics, making less personal statements, and disapproval of the patient’s statement (Bandura, 1956).

While it may appear that all countertransference reactions are negative, this is not the case. Hayes and colleagues found that some manifestations of countertransference led to identification with the patient, compassionate understanding, and further examining the course of treatment (Hayes et al., 1998). It appears that these reactions can actually draw the therapist and patient closer together and these reactions can be used to benefit the therapeutic relationship when applied (and managed) appropriately. It seems plausible that the more resolved an intrapsychic conflict for the therapist, the more likely it will be used to enhance understanding of the patient.
Research on countertransference has also examined therapeutic outcome. In a study of 20 cases of brief therapy, Hayes, Riker, and Ingram (1997) utilized supervisor ratings of countertransference behavior. Supervisors also conducted live supervision of each therapy session and noted when counselors made verbalizations as either approach, avoidant, or neither. After therapy sessions had been terminated, patients were also contacted to complete a questionnaire examining their gain from therapy and satisfaction with counseling. A significant positive correlation was found between outcome and displays of countertransference behavior in cases with moderate to poor outcome. In another study by Ligiero and Gelso (2002), the relationship between countertransference behaviors, therapist attachment styles, and working alliance was examined. Fifty counselors and their supervisors participated in the study. Counselors completed questionnaires on attachment style and working alliance about one patient and their supervisors completed measures of working alliance and countertransference behaviors about the counselor’s work with that particular patient. It was found that countertransference behaviors were associated with poorer working alliances (which predict poor therapy outcome). Similar results were found in a study by Rosenberger and Hayes (2002) in a case study of 13 sessions. It was found that better management of countertransference behaviors led to greater session depth as rated by both the patient and therapist and appeared to benefit the working alliance. Gelso et al. (2002) also examined the relation between therapist trainees’ outcome and countertransference management as judged by their supervisors. It was found that trainees who exhibited better management of these behaviors had better patient outcomes than those trainees who exhibited poorer management of countertransference behaviors.
Countertransference Management

Lastly, countertransference management, the focus of this study, is defined as the therapist’s ability to control his or her “reactions so as to minimize their negative impact on therapy or to facilitate the therapy process” (Hayes, 2004a, p. 29). As it has been examined thus far, countertransference appears to be inevitable in the therapeutic relationship. By understanding the cognitions, feelings, and behaviors of patients, therapists may be informed about what the patient pulls from others. Gelso and Hayes (2007) theorize there are five therapist characteristics which aid in managing countertransference: self-insight, conceptualizing skills, empathy, self-integration, and anxiety management skills. When these characteristics are cultivated within the therapist and enacted, problematic countertransference reactions are less likely to occur. The Countertransference Factors Inventory (CFI; Van Wagoner, Gelso, Hayes, & Diemer, 1991) is commonly used to measure these five factors and will be described in greater detail in Chapter III.

The first of these characteristics is self-insight. Within therapy, self-insight is thought to be vitally important. According to Freud (1910/1959), no patient can develop insight beyond the level of insight of his or her therapist. Countertransference begins in the unconscious so the more a therapist can bring it into consciousness, more likely he or she is able to control for it and it is less likely that a patient’s therapeutic needs will trigger countertransference reactions (Freud, 1910/1959). Bandura (1956) notes that the therapist who has greater insight into him or herself is better able to control these reactions and how they will impact the therapeutic process. The self exploration needed to cultivate insight may be a difficult and uncomfortable task. A study by Baehr (2004) of
12 psychologists’ countertransference management skills found that certain activities facilitated self-awareness. These included free-floating reflection during such activities as exercise and meditation, and self-care to limit both professional and personal stress. Therapists stated that when they felt run-down or burnt out, they were less self-aware. The more aware a therapist is of these motivating forces behind his or her thoughts, feelings, and behaviors, the more likely a therapist is to be able to control for them while in session.

Research on the role of self-insight into countertransference management has produced mixed findings. Using the CFI, self-insight, along with the other four characteristics of countertransference management were found to distinguish colleague-described excellent from average clinicians (Van Wagoner et al., 1991). In a similar study, psychotherapy experts rated self-insight as an important component of countertransference management (Hayes, Gelso, Van Wagoner, & Diemer, 1991). Hayes and colleagues surveyed 33 expert therapists in transference and countertransference to assess which of 50 items were the most important for a therapist to possess in order to manage countertransference effectively. Each of the five factors was deemed as being at least moderately important, with self-insight and self-integration as being particularly important.

Other studies have failed to detect a relation between self-insight and countertransference behavior (Gelso et al., 1995) and therapy outcome (Gelso et al., 2002; Hayes et al., 1997). Gelso et al. (1995) investigated countertransference reactions by examining the reactions of those viewing a tape of either a lesbian or heterosexual patient actress. Findings indicate that countertransference reactions were not correlated
with any of the five countertransference management characteristics. Using the CFI, Gelso et al. (2002) examined the relationship between countertransference management characteristics and therapy outcome. Participants included 32 psychologists-in-training and their supervisors who reported on the trainees’ management abilities using the CFI. While the anxiety management and conceptualization skills subscales were positively related to trainee and supervisor ratings of therapeutic outcome, self-insight and empathy were not found to be correlated. Self-integration was found to be correlated only with the trainees’ ratings of outcome, but not supervisors’ ratings of outcome.

Conceptualization skills are the second characteristic of countertransference management. Two studies have confirmed the hypothesis that therapists would display less countertransference behavior when they had awareness of it and were able to reference a theory to understand their reactions to patients (Latts & Gelso, 1995; Robbins & Jolkovski, 1987). Latts and Gelso examined 47 counseling trainees’ awareness of countertransference and their “approach” and “avoidance” behaviors with a patient-actress portraying a survivor of date rape. An interaction effect was found between awareness of countertransference and theoretical framework on avoidant behaviors such that these behaviors increased as awareness of countertransference and adherence to a theoretical framework decreased. Robbins and Jolkovski (1987) conducted a similar study and found that high awareness of countertransference feelings along with high ratings of theoretical framework led the counselor trainee to display the least withdrawal of involvement within a session. Arguably, to prevent countertransference behavior, it is necessary for a therapist to have enough self-insight to realize they are experiencing countertransference reactions and it is helpful to have a theory to help ground these
reactions (Gelso & Hayes, 2007). From this research, it appears that a theoretical framework is helpful to conceptualize patients so as to minimize countertransference reactions. However, the lack of a main effect for self-insight suggests that by itself, conceptualization skills may not be enough to effectively manage countertransference or perhaps, it has not been studied sufficiently to date.

Gelso and Hayes (2007) state that in addition to self-insight and conceptualization skills, countertransference may be managed with empathy. Empathy involves dwelling in the patient’s world, without thoughts of one’s own needs, wants, conflicts, or issues (Bohart, Elliott, Greenberg, & Watson, 2002; Gelso & Hayes, 2007). According to psychoanalytic theory, both countertransference feelings and empathy are the result of identification with the patient (Peabody & Gelso, 1982). Empathy allows the therapist to experience a part of what the patient is experiencing, thereby maintaining the focus on the patient; however, countertransference emerges when this experience touches off an unresolved issue of the therapist (Peabody & Gelso, 1982). At these times, it is difficult for the therapist to maintain an appropriate therapeutic distance from the patient without over or under identifying. Gelso and Hayes (2007) state that an empathic stance holds that middle ground.

Research findings support the idea that empathy is a characteristic of therapists who are able to manage their countertransference. Hayes et al. (1997) found an inverse relationship between empathy and countertransference behavior among therapist trainees as judged by their supervisors. Participants included 20 doctoral level counselor trainees and their previous supervisors. These supervisors rated the counselors on the five factors...
of countertransference management using the CFI. Findings indicated that countertransference behavior was inversely related to counselors’ empathy.

In order to empathize with patients without losing focus and having the experience touch an unresolved issue, it is important for the therapist to be fully integrated. The quality of self-integration, another component of countertransference management, is defined as the therapist’s sound psychological health which allows the therapist to differentiate from patients and engage in appropriately distanced behavior (Hayes et al., 1991). It is believed that therapists with fewer personal conflicts are more integrated and will be less likely to engage in countertransference thoughts and behavior. Data from Hayes et al. (1997) indicate that countertransference behavior is inversely related to self-integration. Additionally, therapists who are self-integrated are able to recognize a therapeutic relationship with appropriate personal distance is necessary for a positive therapeutic alliance (Gelso & Hayes, 2007).

Research has been conducted to determine how therapists maintain psychological well-being; specifically during therapy, therapists use techniques such as self-coaching, thought stopping, refocusing, and breathing (Baehr, 2004; Williams, Polster, Grizzard, Rockenbaugh, & Judge, 2003; Williams et al., 1997). In between sessions, therapists seek their own therapy and peer consultation to manage countertransference (Baehr, 2004; Williams et al., 2003).

Lastly, anxiety management is another factor which has been theoretically postulated and empirically supported as important in managing countertransference. Therapist anxiety is a common reaction to one’s unresolved conflicts being provoked by a patient (Fauth & Hayes, 2006; Gelso et al., 1995; Hayes & Gelso, 1991, 1993; Latts &
Gelso, 1995). Research has found that both trait and state anxiety are predictors of countertransference behavior (Gelso et al., 1995; Hayes et al., 1998; Hayes & Gelso, 1991; Yulis & Kiesler, 1968). It appears that anxiety is both a precursor and a result of countertransference reactions. For example, Williams et al. (1997) found that in psychologist trainees, anxiety about personal therapeutic skills, performance, and reactions to patient content within the session led to negative reactions, avoiding affect, and over-focusing on patient’s issues while losing objectivity. Research also supports the claim that therapists who are better able to manage their anxiety will be less likely to enact countertransference behaviors in session (Fauth & Williams, 2005; Gelso et al., 1995; Gelso et al., 2002; Hayes & Gelso, 1991; Yulis & Kiesler, 1968). Fauth and Williams (2005) found that among counselor-trainees, in-session self-awareness predicted over 50% of the variance in both the trainees’ interpersonal involvement in session and the patients’ perceptions of the therapeutic alliance. In a related study, Gelso et al. (1995) used the CFI and an anxiety inventory to assess anxiety management skills in male and female counselors. It was found that greater anxiety management skills used in session along with greater self-integration were connected with reduced self-reported feelings of anxiety in session. Gelso et al. (2002) used the CFI-R to examine the relation between therapist trainees’ outcome and countertransference management as judged by their supervisors. Researchers found that trainees who exhibited better management of countertransference behaviors had better patient outcomes than those trainees who exhibited less ability manage these feelings.

An important advancement in the study of countertransference management was the development of the CFI and CFI-R. As referenced in many of the previously
examined studies, the CFI was created to examine five aspects of countertransference management by a supervisor or someone familiar with the clinical work of the therapist. Specifically, the initial study by Van Wagoner et al. (1991) found that excellent therapists were rated higher on all five dimensions of the CFI than therapists in general. In a case study, Rosenberger and Hayes (2002) found that an experienced therapist’s self-ratings on the CFI for each session were positively correlated with the patient’s ratings of working alliance and session depth. The research largely indicates support for the five specific therapist characteristics which make up the CFI (Baehr, 2004; Fauth & Williams, 2005; Gelso et al., 1995; Gelso et al., 2002; Gelso & Hayes, 2002; Gelso & Mohr, 2001; Hayes et al., 1997; Hayes et al., 1998; Latts & Gelso, 1995; Rosenberger & Hayes, 2002; Williams & Fauth 2005; Williams, et al. 1997; Williams, et al. 2003).

Overall, from this review of the countertransference literature and specifically, countertransference management factors, it is evident that a body of theoretical and empirical research exists establishing the association between self-insight, conceptualizing skills, empathy, self-integration, and anxiety management skills, with fewer countertransference cognitions, feelings, and behaviors. However, to date, no research exists examining therapist characteristics that may directly cultivate the presence and success of executing these countertransference management skills. The remainder of this chapter will examine emotional intelligence and self-efficacy as possible factors which may enhance a therapist’s ability to utilize these characteristics and manage countertransference.
Emotional intelligence

Classical psychoanalysis and the classical view of countertransference would have us believe that it is better to leave one’s emotions at the door when conducting therapy, similar to Freud’s idea that a psychotherapist should utilize emotion as much as a surgeon (Freud 1912/1959). In fact, Freud was conflicted about whether a therapist’s emotions could be helpful in understanding a patient (Gelso & Hayes, 2007). Similarly, research during the first half of the 20th century developed a mistrust of emotion, believing that it muddles thinking and causes irrational decisions (Salovey, Bedell, Detweiler, & Mayer, 2000). However in recent years, contemporary research has revealed that suppressing or denying the impact of our emotions or their role in decision-making and behavior may not be desirable or even possible (Damasio, 1994, 1999; Druskat, Sala, & Mount, 2006; Lewis & Haviland-Jones, 2000; Ollilainen, 2000). Currently, it is generally accepted that emotions enhance, rather than hinder, our cognitive abilities (Druskat et al., 2006).

Emotions are generally defined as a state of arousal in response to a perceived stimulus which involves psycho-physiological reactions, cognitive appraisals, and subjective reactions (Frida, 2000). Emotions contribute unique information about the surrounding environment which in turn informs subsequent thoughts, actions, and feelings (Salovey et al., 2000). Researchers have found that emotions inform our decisions within the brain, helping to code what and how we learn and remember (Damasio, 1994, 1999; Forgas, 2006). Further research suggests that people differ in their ability to perceive, understand, and use emotion (Damasio, 1994, 1999). Mayer and
Salovey have studied this ability to use emotion to accurately perceive and facilitate thought; they define this ability as emotional intelligence (Salovey et al., 2000).

Modern precursors to the current understanding of emotional intelligence date back at least as far as research in the separate fields of intelligence and emotion (Mayer, Salovey, & Caruso, 2004). During this time, tests for intelligence were being developed as was research into emotion and its physiological components (Mayer, 2006). Specifically, it appears that Thorndike, a founding authority of intelligence, was the first modern psychologist to define the general concept in 1920 (Bar-On, Handley, & Fund, 2006). He hypothesized that intelligence was comprised of several abilities including social intelligence, which he defined as the ability to understand others and manage others during human relations (Thorndike, 1920). He believed that this type of intelligence was innate, much as finger prints and eye color. However, he also believed that social intelligence, via the environment and training, could be improved or injured (Thorndike, 1920).

Over the next 70 years, research into cognition and affect and their interactions developed including studies into nonverbal communication and artificial intelligence (Mayer, 2006). Researchers such as Guilford (1956) and Gardner (1983) studied and challenged the traditional assumptions of intelligences. They stated that intelligence includes more than simply an intellectual ability. Rather, it is necessary to include both social and emotional skills into a definition of intelligence (Gardner, 1983).

The first conceptual foundation for the current understanding of emotional intelligence appeared in 1990, as Salovey and Mayer combined much of the previous research to establish emotional intelligence as a separate psychological field of study with
the belief that humans are not predominantly rational or emotional beings; rather they are both (Salovey et al., 2000). Since then, emotional intelligence has gained in popularity, especially with the book, *Emotional Intelligence*, by Daniel Goleman (1995), and articles in *Time* and *USA Today Weekend* magazines. These works, however, have overstated the impact of emotional intelligence, by asserting that once acquired and mastered, it could bring virtually infinite success and achievement of one’s goals (Mayer et al., 2000).

In terms of psychotherapy, emotional intelligence may help psychologist trainees to better understand and accurately perceive emotion with their patients, thereby enhancing countertransference management skills. To date, however, emotional intelligence and countertransference management have not been examined together.

Scientific research has examined the nature and definition of emotional intelligence with two major conceptual models standing out: the mixed model, which includes Bar-On’s and Goleman’s models and, the ability model as conceptualized by Salovey and Mayer, the focus of this paper.

*Defining emotional intelligence*

Conceptualizing a definition of emotional intelligence is necessary as the term has several different definitions depending on which researcher of emotional intelligence is being studied. Only a brief review of Goleman’s and Bar-On’s models will be explored for the purpose of comparison to the Salovey-Mayer ability model of emotional intelligence.

*Mixed model definition of emotional intelligence*. The mixed model of emotional intelligence generally describes emotional intelligence as “an array of non-cognitive capabilities, competencies, and skills that influence one’s ability to succeed in coping
with environmental demands and pressures” (Bar-On, 1997, p.14). According to this definition, emotional intelligence examines individual self-perceived abilities, personality traits, and skills (Brackett & Mayer, 2003) which mix attributes outside emotional intelligence (Brackett & Mayer, 2007). This definition considers emotional intelligence to be broad and multidimensional (Daus & Ashkanasy, 2005).

Goleman’s journalistic and pop-culture account of emotional intelligence popularized the term in the mid 1990’s. His definition of emotional intelligence is broad compared to Mayer and Salovey’s definition, in that it only describes the attributes of personality dimensions which may be associated with emotional intelligence. Further, it has been argued that due to its broad nature, Goleman’s description of emotional intelligence encompasses all aspects of personality (Mayer et al., 2000). This definition includes five parts: knowing emotions, managing emotions, motivating oneself, recognizing emotions in others, and handling relationships (Goleman, 1995). Goleman (1995, 1998) lists 25 abilities and attributes of emotional intelligence which, he states, can out-predict IQ and is even twice as important as IQ (Goleman, 1998). Goleman attempted to clarify his position by downplaying his assertions in 1995, and to date, research has not supported these claims (Davies, Stankov, & Roberts, 1998; Mayer & Cobb, 2000; Mayer et al., 2000).

Goleman’s model of emotional intelligence is measured with the Emotional Competency Inventory (ECI and ECI-2; Boyatzis & Sala, 2004) which assesses work-related emotional competencies. Specific to this measure, emotional intelligence is defined as, “an ability to recognize, understand, and use emotional information about oneself or others that leads to or causes effective or superior performance” (Boyatzis &
Sala, 2004, p. 147). It uses both self-report and relevant observer reports to assess 18 competencies. Overall, it appears that this measure predicts work-related outcomes well, correlates with job performance, and is not associated with other personality factors (Brackett & Mayer, 2003).

Bar-On’s model of emotional intelligence “describes a cross-section of interrelated emotional and social competencies, skills, and facilitators that impact intelligent behavior as measured by self-report within a potentially expandable multi-modal approach” (Bar-On, 2006, p. 2). Bar-On’s model is founded in Darwin’s early conceptualization of emotional-social intelligence supporting the importance of emotional expression and that emotions are adaptive in nature (Bar-On, 2006). From this model, an emotionally (and socially) intelligent individual manages personal and social change by making decisions and solving problems (Bar-On, 2006). In order to do this, it is necessary to manage emotions, be self-motivated, and have an optimistic and positive outlook on life (Bar-On, 2006).

Bar-On created the Emotion Quotient Inventory (EQ-i) to measure his conceptualization of emotional intelligence via self-report (Brackett & Geher, 2006). This measure has five constructs: interpersonal skills, intrapersonal skills, stress-management, adaptability, and general mood. The EQ-i is found to be highly correlated with many personality measures including anxiety, depression, alexithymia, and the Big Five traits (Brackett & Geher, 2006). Overall it is found that older people score better than younger people, females score better than males, and males score higher on the ability to manage emotions (Bar-On, 2006).
Because both Goleman and Bar-On’s conceptualizations of emotional intelligence involve one’s perceived abilities, and not actual abilities, inventories are self-report. However, Mayer, Roberts, and Barsade (1997) argue that this form of response is not valid for an assessment of mental ability. Self-report or self-judgment testing draws on the individual’s self-concept and present mood, but it is difficult to measure mental abilities because people are relatively poor judges of their own capabilities (Mayer, 2006), and people tend to answer questions in a socially desirable manner or overly positive manner (Paulhus, Lysy, & Yik, 1998). For example, scores on criterion-report tests of intelligence tend to correlate with self-judged intelligence at a near-chance level (Paulhus et al., 1998).

An ability model of emotional intelligence

Due to varying definitions as well as the inflated claims being made on behalf of the emotional intelligence construct, Mayer, Salovey, and Caruso (2000) began to research and distinguish their ability model of emotional intelligence from existing models. Mayer and Salovey’s definition of emotional intelligence, which will be used for this study is:

the ability to perceive accurately, appraise, and express emotion; the ability to access and/or generate feelings when they facilitate thought; the ability to understand emotion and emotional knowledge; and the ability to regulate emotions to promote emotional and intellectual growth (Mayer & Salovey, 1997, p.10).

This definition conceptualizes emotional intelligence as an intelligence which is informed and benefits from the input of emotions (Mayer et al., 2000). Mayer and colleagues
believe that intelligence is used to problem solve while emotions arise out of abstract thought (Mayer et al., 2000). This theory of emotional intelligence is well supported in the psychological community as Daus (2006) states that the ability model of emotional intelligence reflects both classic and recent thoughts about the primacy of cognition and emotion together. Mayer and Salovey believe that emotions arise in response to changing personal relationships which are either external changes or internal perceptions of change (Mayer et al., 2000). As relationships change, so do emotions and the meaning of the relationship (Mayer et al., 2000).

Mayer and Salovey’s ability model of emotional intelligence is described as a set of mental abilities (Brackett & Geher, 2006) which are conceptualized into four branches: reflective regulation of emotion, emotional facilitation of thought, understanding and analyzing emotions, and perception, appraisal, and expression of emotion (Mayer & Salovey, 1997). The branches develop in complexity of emotion and intellectual growth, from basic psychological processes to more complex. The lowest branch (Branch One) consists of relatively simple abilities in perceiving and expressing emotion (Mayer & Salovey, 1997). The highest branch (Branch Four) involves conscious and reflective regulation of emotion (Mayer & Salovey, 1997). Moving from left to right, these abilities develop from childhood to adulthood. Emotionally intelligent individuals are better able to master the abilities than less emotionally intelligent people as described by this model.

**Branch One: Perception, appraisal, and expression of emotion.** Branch One pertains to one’s ability to identify emotions and emotional content. Mayer and Salovey describe this maturation process from infancy to adulthood. An infant learns to differentiate his or her own general emotional states and eventually differentiate between
them. Additionally, infants are able to recognize facial expressions of caregivers and respond to them. Adults are able to distinguish emotional states and complex feelings within one situation. For example, an adult is able to feel anxious, happy, and nervous all at the same time, rather than simply feeling “excited” as a child might say. Along with the ability to distinguish emotional states comes the ability to generalize feelings from oneself to another person, and thereby recognize expressions of others. An emotionally intelligent individual is able to express and recognize emotion and is also sensitive to false or manipulative expression (Mayer & Salovey, 1997). It is believed that individuals who are emotionally intelligent are better able to respond to their environment in an appropriate manner as well as build a supportive social network (Salovey et al., 2000).

The ability to perceive and express emotion is an important aspect of managing one’s countertransference as it allows a therapist to recognize and react to his or her own emotions while in a therapy session. Gelso and Hayes (2007) describe in their model of countertransference management the importance of self-insight and empathy in managing one’s reactions to patient’s material. Self-insight may be described as the awareness of one’s own emotions while empathy is one’s ability to recognize and identify with a patient’s emotions (Peabody & Gelso, 1982). Thus, self-insight and empathy are countertransference management factors which may be promoted by the characteristics captured by Branch One of the ability-based model of emotional intelligence.

Branch Two: Emotional facilitation of thinking. This branch examines how emotion is influenced by intelligence. From birth, emotions serve as a warning system to alert and inform us of changes in the individual and the environment. A baby may cry if he or she is hungry or cold. An adult may feel anxious about work that is not completed.
As humans grow older, they are able to use emotions to inform their decisions and direct attention to important internal and external changes (Salovey et al., 2000). Gelso and Hayes (2007) highlight the importance of cognition in preventing countertransference behavior as it is necessary for a therapist to have enough insight to realize they are experiencing countertransference reactions and it is helpful to have a theory to ground these reactions. By using emotions to facilitate thought, therapists can use their emotions to alert them to changes in the reactions to patients.

This also includes the development of “on demand” thinking to generate emotions. If a child is asked what a character in a story is feeling, the child may draw on his or her own feelings. Adults with more developed emotional intelligence are able to generate, feel, manipulate, and examine emotions and use them to direct decision making.

Another ability contained within Branch Two is consideration of multiple perspectives based on the given mood. For example, someone who is feeling slightly depressed may not consider talking to people at a work luncheon, while this same person who is feeling more optimistic might talk to several people to network with other professionals. It is also believed that emotionally intelligent individuals are able to harness motivational qualities in order to create an advantageous mood for a given situation (Salovey et al., 2000). For example, in therapy a given level of conscientiousness is desirable among therapists and an emotionally intelligent therapist has the ability to effect emotions to create this state of mind (Salovey et al., 2000).

*Branch Three: Understanding and analyzing emotions; employing emotional knowledge.* This branch describes the ability to understand emotion and use emotional knowledge. Mayer and Salovey (2002) state that as children grow older, they are able to
recognize the relation between emotions such as like and love, and annoyance and anger. Children are also learning how these emotions are linked in relationships and situations. For example, children learn that they feel guilty when they steal something. The most fundamental ability of this branch is the ability to label emotions with words (Salovey et al., 2000). Emotional knowledge increases with experiences and understanding of emotional meanings which may include complex emotions and blends of emotions such as hope being a combination of faith and optimism (Mayer & Salovey, 1997). In addition, an emotionally intelligent individual learns that emotions can provoke other emotions and behaviors and recognizes the transition among emotions (Salovey et al., 2000). Branch Three demonstrates again, the importance of empathy in managing countertransference. Knowledge of complex emotions and how they may be observed in both the patients and therapists is helpful when managing countertransference reactions.

*Branch Four: Reflecting regulation of emotion to promote emotional and intellectual growth.* The highest of the four branches requires that the individual is able to tolerate and even welcome emotional reactions when they occur, regardless of how pleasant or unpleasant they are. However, a person must attend to these feelings in order to learn from them. Openness to feelings is the first step in this process. Children are taught what feelings to express and what are the appropriate actions for these feelings. For example, children are taught that it is not appropriate to hit a sibling because they feel frustrated, but it is appropriate to smile when one feels happy. Children eventually learn to internalize the divisions between feelings and behaviors, understanding that feelings cannot always be acted upon. Children learn to disengage from emotions as necessary. Eventually as individuals mature, they are able to reflect on their own feelings for
example, “I don’t understand why I’m feeling like this,” or “This feeling is influencing my thinking.” Mayer and Salovey (1997) state that these thoughts are “conscious reflections on emotional processes” (p. 14). These meta-analyses of mood are made up of meta-evaluation of the feeling and meta-regulation of the feeling. This includes how much attention is given to a particular feeling and how influential a mood is to an experience (Mayer & Salovey, 1997). Mood maintenance and mood repair come from the knowledge of emotion which enables individuals to bring about desired feelings (Salovey et al., 2000). Emotionally intelligent individuals who are able to regulate the emotions of others effectively are better able to build and maintain social networks (Salovey et al., 2000).

Branch Four describes the anxiety management and psychological well-being factors of countertransference management. Mayer and Salovey state that by reflecting on one’s emotional processes, both evaluative and regulative of emotions. This is specifically important when managing countertransference as it allows a therapist to manage feelings such as anxiety while in session with a patient. Regulation of emotion is used both in a therapy session and between sessions (Baehr, 2004) to more fully understand personal conflicts which arise during work with patients. It can therefore be hypothesized that evaluation and regulation of one’s own emotions will allow for improved management of countertransference behaviors.

The ability or performance model of emotional intelligence is tested using the Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT; Mayer, Salovey, & Caruso, 2002). The MSCEIT is a criterion-report test which examines how an individual performs tasks and solves emotional problems compared to expert or general norms.
Rather than simply asking for a self-report for a person’s subjective assessment of their emotional skills, the MSCEIT is a computer-based test of performance on such tasks as identifying emotions from pictures and blending two emotions to create one. This measure will be examined further in the next chapter.

The Emotionally Intelligent Therapist

Psychological work with patients is stressful at times and external demands require the psychologist to use internal coping resources. Louie, Coverdale, and Roberts (2006) and Martin, Easton, Wilson, Takemoto, and Sullivan (2004) argue that similar to psychologists, psychiatrists’ work can be emotionally draining as they simultaneously encourage patients to experience sadness, fear, and anger, while also managing their own emotions and countertransference. Louie et al. state that aspects of emotional intelligence such as awareness of one’s own and others’ emotions, and the regulation of both one’s own and others’ emotions, are essential to therapeutic work. Having high emotional intelligence may facilitate more effective coping in a stressful situation by correctly perceiving, understanding, and regulating self and others’ emotions (Zeidner, Matthews, & Roberts, 2004). It is hypothesized that having greater emotional intelligence will help psychologist-trainees by facilitating the development of countertransference management characteristics including self-insight, conceptualizing skills, empathy, self-integration, and anxiety management skills.

Self-integration. Self-integration has been found to be moderately correlated with the ability-based model of emotional intelligence (Schutte, Malouff, Thorsteinsson, Bhullar, & Rooke, 1998). Schutte and colleagues performed a meta-analysis examining emotional intelligence and mental health based on the responses of 7, 898 participants in
35 studies. A total of 44 effect sizes were found examining the relation between health and emotional intelligence, with 33 specifically looking at mental health. Researchers found that the 33 effect sizes examining mental health and emotional intelligence found a weighted average of $r = .29$, indicating that “it may be that the better perception, understanding, and management of emotion of individuals with higher emotional intelligence make it less likely that they will experience mental health problems” (p. 929).

Additionally, the MSCEIT total score has been found to correlate positively with psychological well-being (Brackett & Mayer, 2003; Brackett, Rivers, Shiffman, Lerner & Salovey, 2006). In a study of 207 predominantly Caucasian college students, Brackett and Mayer found a correlation of .28 between emotional intelligence and psychological well-being. In a later study, Brackett and colleagues also found a significant correlation ($r = .24$) between emotional intelligence and psychological well-being among 355 college students (61% female, 58% Caucasian, 19% Asian, 9% African American, 6% Hispanic).

Research also indicates a link between emotional intelligence and relationships with others (Austin et al., 2004; Lopes et al., 2004). Using a self-report measure of emotional intelligence, Austin and colleagues surveyed 500 undergraduates from Canada and 204 people from Scotland (180 adult volunteers, 34 undergraduates). They found that emotional intelligence was negatively correlated with alexithymia ($r = -.64$) and positively correlated with life satisfaction ($r = .33$), social network size ($r = .27$), and quality of relationships ($r = .25$). In a similar study, Lopes et al. found a significant correlation between the ability to manage emotions and the quality of social interactions (positive interactions, $r = .31$; negative interactions, $r = -.12$) in 118 college students. From this
research, it appears that emotionally intelligent individuals are more likely to a stronger quality of relationships and greater life satisfaction. Each of these elements are important in maintaining psychological health and self-integration. According to Hayes and Gelso (2007), this will allow for better management of countertransference reactions.

According to Matthews and colleagues (2006), difficulty in processing emotional material may be due to a maladaptive coping style. In a study of 200 college students, these researchers found a negative correlation between emotional intelligence and base-state distress and worry (Matthews et al., 2006). Findings also included an association between emotional intelligence and lower avoidance coping during stressful situations. However, this study failed to confirm the hypothesis that higher emotional intelligence would reduce the magnitude of task-induced stress responses, leaving the question of how emotional intelligence is used during stressful situations.

Anxiety management. Empirical research to date does suggest that emotional intelligence may enhance coping abilities, stress reduction, adaptation to novel situations, and even physical health. Each of these intrapersonal dimensions of emotional intelligence may be interpreted as critical factors in augmenting self-integration, anxiety management, and self-insight. In a study by Montes-Berges and Augusto (2007) it was found that in 119 first-year nursing students, the attentional component of self-reported emotional intelligence was positively associated with using active coping strategies including emotional regulation. The nursing students who had greater emotional clarity were able to identify specific emotions during stressful situations allowing them to invest the correct cognitive resources needed to achieve a more adaptive coping strategy. Emotional clarity was negatively associated with behavioral and cognitive avoidance
coping strategies. Lastly, it was found that self-perceived emotional intelligence was positively associated with mental health. These findings are consistent with previous findings by Gohm and colleagues (Gohm, 2003; Gohm, Baumann, & Sniezek, 2001; Gohm & Clore, 2002) in which clarity was positively correlated with measures of positive well-being and inversely associated with measures of negative well-being.

Empathy. It has also been maintained that empathy is a desirable and even required quality of a therapist to manage countertransference thoughts, feelings, and behaviors (Gelso & Hayes, 2007). Empathy requires the accurate identification of emotional responses in others (Mayer, DiPaolo, & Salovey, 1990). It is also thought to be an ability rather than an attitude held by the individual (Mayer & Salovey, 1997). Self-reported empathy has been found to demonstrate moderate to strong correlations with emotional intelligence as measured by the MSCEIT (Brackett et al., 2006; Mayer, Caruso, & Salovey, 2000). Mayer and colleagues surveyed 503 adults (164 male) with a mean age of 23 years drawn from several sources including college students, corporate employees, and workshop attendees. Empathy was found to be positively correlated \(r=.36\) with emotional intelligence and other researchers have found that emotional intelligence also correlates with openness to feelings, clarity of feelings, and openness to experience (Schutte et al., 2001). Schutte et al. also found that therapists scored higher in emotional intelligence compared to patients in a drug rehabilitation clinic.

Schutte et al. (2001) also examined empathy and emotional intelligence in two studies. These studies have found a strong, replicated correlation between emotional intelligence and empathic perspective, a subscale of a self-report empathy scale \(r=.35, .59\). However, emotional intelligence was not correlated with other aspects of empathy.
including empathic fantasy, empathic concern, and personal distress. The authors suggest that empathic perspective taking is more emotionally adaptive than the other three dimensions. Contrary to the findings of Schutte et al., Pacheco and Berrocal (2004) found that ability-based emotional intelligence (specifically emotion management) was significantly correlated with empathic concern. In a similar study, researchers examined the potential influence of self-reported emotional intelligence on emotional responses (empathy) after witnessing a stressful event (Ramos, Fernandez-Berrocal, & Extremera, 2007). Empathy and emotional intelligence were found to be highly correlated, suggesting that certain individuals were able to become emotionally involved with the characters of the event they witnessed and had a greater understanding of the character’s suffering, compared to those individuals with less emotional intelligence.

Empathy and emotional intelligence were also examined in 211 counseling graduate students in a study by Miville, Carlozzi, Gushue, Schara, and Ueda (2006). The researchers’ hypothesis was confirmed that emotional intelligence was moderately related to three dimensions of empathy: perspective taking, emotional concern, and personal distress. This suggests that emotional intelligence may be a helpful quality to counselors who must be able to empathize with patients. This study also found that counselors who had greater emotional intelligence also experienced less personal distress, suggesting that those counselors who are more emotionally intelligent may be better able to manage their countertransference and will be less likely to display countertransference behaviors (Miville et al., 2006).

Other areas of emotional intelligence research have examined relationships and social interactions. Research has also found that higher emotional intelligence scores
among close friends correlated with higher self-perceived competence in reacting to friends’ life events, and in making fewer active and passive critical and destructive remarks (Brackett & Geher, 2006; Lopes, Salovey, & Straus, 2003). In social interactions with friends, it has been found that one’s ability to manage and regulate emotions can predict successful interactions beyond what personality or intelligence can predict (Lopes et al., 2004). Persons found to be more emotionally intelligent were found to be more valued and liked by members of the opposite sex, more socially adept, and more securely attached (Lopes et al., 2004).

Overall, the research indicates that emotional intelligence may benefit those in the helping professions by enhancing skills which help to manage countertransference. These include coping and regulation of expressive behavior, awareness and understanding of the causes and consequences of one’s own mood, coping with stressful situations, empathic accuracy, and the ability to understand, express, and manage one’s own emotions (Ciarrochi & Godsell, 2006). These qualities help to develop positive relationships, prevent one’s mood from influencing judgment and behavior, and improve mental and physical health (Ciarrochi & Godsell, 2006). The research studies reviewed have found a positive association between self-perceived emotional intelligence and psychological well-being (Brackett & Mayer, 2003; Gohm, 2003; Montes-Berges & Augusto, 2007; Schutte et al., 1998), including greater use of positive coping strategies and reduced use of negative coping strategies (Austin et al., 2004; Brackett et al., 2004; Lopes et al., 2004). Emotional intelligence has also been found to be inversely correlated with anxiety and feelings of worry and distress (Bastian, Burns, & Nettelbeck, 2005). Additionally, several studies have found that higher levels of emotional intelligence are positively
correlated with increased empathy (Miville et al., 2006; Ramos et al., 2007; Schutte et al., 2001). Overall, it appears that emotional intelligence is related to all five components of countertransference management, empathy, self-integration (well-being), self-insight, conceptualization skills (perspective taking), and anxiety (emotional) management skills.

Counselor Self-Efficacy

Another construct which appears to be theoretically related to the five components of countertransference management is counselor self-efficacy (CSE). CSE was adapted from Bandura’s theory of self-efficacy which is only one construct embedded in Bandura’s Social Cognitive Theory (SCT). In order to understand the basis of CSE, a thorough review of Bandura’s theory of self-efficacy is required. The review focuses on the relation between one’s goals and expectations and emphasizes the role of modeling, self-regulation, and interpretation of outcomes in acquiring psychosocial patterns of behavior (Bandura 1961, 2004). Bandura defines self-efficacy as one’s beliefs about his or her own ability to perform a given behavior and a “generative capability in which multiple sub-skills must be flexibly orchestrated in dealing with continuously changing realities, often containing ambiguous, unpredictable, and stressful elements” (Bandura, 1984, p. 233). Self-efficacy determines how people feel, think, motivate, and behave.

Bandura’s Theory of Self-Efficacy

From an SCT perspective, Bandura notes that self-efficacy is influenced by the person, his or her behavior, and the surrounding environment. This interaction between a) environmental variables, b) human behavior, and c) personal factors, including the cognitive-affective processes of the person, is called triadic reciprocal determinism.
Bandura believes that people are not only reactors to external stimuli but actually determine for themselves how the environment will be interpreted (Bandura, 1977, 1978). Triadic reciprocity is an important concept when understanding perceived self-efficacy because it is the personal factor within the triangular model of causality, and self-efficacy will influence achievement factors including choice of behaviors, persistence, effort expended, and skill acquisition (Schunk, 2000). Self-efficacy in turn influences the person’s behavior, and behavior influences self-efficacy. As a person is able to identify his or her progress at skill acquisition and performance, self-efficacy will increase along with motivation to perform and effort expended.

From the concept of reciprocal determinism, Bandura also posits that people can self-regulate their environmental, behavioral, and personal aspects of life through self-observation, a judgmental process, and self-responsiveness (Bandura, 1978). Self-regulation occurs first by self-observation in which the person examines his or her own behavior in terms of quality, quantity, originality, ethicality, and so forth. For a training therapist, this may become evident in supervision, coursework, through one’s own therapy, and over the course of therapy with patients. However, these comparisons cannot be made without personal standards against which to evaluate the behavior as adequate or inadequate. These standards are most often set via societal norms, reference groups, or one’s previous behavior. It would be expected that a therapist in training would reference his or her own progress in attaining counseling skills against peers, his or her supervisor, and grades in classes. Lastly, the development of self-efficacy depends on how an individual responds to success and failure. Schunk (2000) notes that persons with low self-efficacy may avoid tasks and expend less effort and persist for less time than
individuals with high self-efficacy. In addition, persons usually do not judge efficacy on tasks which are routine or in which they are highly skilled. Rather, efficacy is judged on tasks which are novel and currently being learned.

Another important area addressed in SCT is how self-efficacy affects human functioning. Specifically, Bandura believes it does so through four major psychological processes: cognitive, motivational, affective, and selection processes. The effects of self-efficacy on cognitive processes are evident in personal goal-setting and the forethought necessary to do so (Bandura, 1994). Defined as the “thinking processes involved in acquisition, organization, and use of information,” Bandura states that much of human behavior is purposive and therefore regulated by cognitions (Bandura, 1994, p. 71). Because most action is cognitively organized, people’s belief in their efficacy will cause them to anticipate, construct, and rehearse scenarios in line with their efficacious beliefs. Those who believe that they are strong in a given area will visualize themselves succeeding and will set appropriate but challenging goals while using analytic thinking to accomplish the task (Bandura, 1994).

Motivation, as noted earlier, is another area predominately regulated by cognition; it is the activation to do something and the intensity and persistence to continue (Bandura, 1994). People use forethought to form beliefs about their efficacy and the anticipated outcomes; determine what goals are accomplishable; and decide how to go about accomplishing these goals. Motivation also dictates how much effort will be expended and how the person will deal with setbacks (Bandura, 1994).

People’s beliefs about their coping abilities will affect their level of self-efficacy as well as their motivation. A person’s affective processes play a central role in
exercising control over stressors and threats within the given environment (Bandura, 1994). If someone believes that she or he cannot control threats in the environment, he or she will experience high anxiety arousal and potentially depression, and will grossly exaggerate much of the environment as dangerous (Bandura, 1994). Because of the extra mental effort required to conjure up distressing possibilities, the person becomes debilitated (or at least impaired) in his/her ability to make decisions and complete tasks (Bandura, 1994). This same process occurs with internal threats as well. Disturbing thoughts alone are not viewed as a problem; rather, it is when self-efficacy is unable to control one’s own thought process that it creates a major source of distress (Bandura, 1994). This “thought control efficacy” works with coping self-efficacy to reduce anxious and avoidant behavior (Bandura, 1994).

Lastly, selection processes, or the environment we choose to be in, can shape our self-efficacy and self-efficacy shapes our environment. Beliefs of self-efficacy will determine what activities we participate in, who we surround ourselves with, and how we construct our environment (Bandura, 1994). With low self-efficacy, a person may only join activities which she knows she is good at, thereby never attempting anything new and not meeting anyone engaging in a new activity. Personal environmental selections can impact an entire life course and therefore are a vital aspect to consider in the importance of self-efficacy (Bandura, 1994). Bandura (1994) notes that the development of coping capabilities and skills to manage one’s motivation, emotional states and thought processes will increase self-regulatory efficacy, and in effect, occupational performance. Bandura also explains that there are four sources which influence the development of self-efficacy: mastery experiences, social modeling (vicarious learning),
social persuasion (verbal persuasion), and personal attributes (physiological and emotional arousal; Bandura, 1977, 1994, 2004).

Mastery experiences (or performance accomplishments) are those experiences in which persistent effort is required to learn the behavior, such as long division or no longer being fearful of riding in elevators (Bandura, 1977, 2004). Bandura calls these experiences the most influential source of efficacy (Bandura, 1977). When mastery occurs self-efficacy as well as resiliency to failure is increased which in turn enhances one’s ability to learn a more complicated behavior (Bandura, 2004). If someone only experiences easy successes, failure can be easily discouraging (Bandura, 1994). However, some setbacks are useful in teaching that success does require sustained effort (Bandura, 1994).

Social modeling also increases one’s self-efficacy by observing similar persons succeed at a given skill after sustained effort (Bandura, 1994). Social modeling can be done by a more competent member at the given skill, such as a teacher or supervisor. Specifically, supervisors can help build self-efficacy in their supervisees by conveying skills and knowledge needed for managing environmental and session demands (Bandura, 2004). For example, a supervisor who is working with a supervisee with a depressed patient can model how to be empathic and what techniques may be helpful from a given theoretical perspective. The greater the similarity (or prestige) the model is to the learner, the greater the impact of the model’s successes or failures (Bandura, 1994). Not only do the models teach modes of accomplishing goals, they also transmit their ways of thinking and other pertinent knowledge about success (Bandura, 1994).
Supervisors who want to foster high self-efficacy in training-counselors can do so by reminding or persuading counselors of their abilities to succeed at a given task. SCT contends that if someone believes they will succeed, they are likely to exert more effort than if they have low self-efficacy for success in the task (Bandura, 1994). However, Bandura says that a teacher or persuader can do more than simply convince the person of their abilities. Rather, it is necessary to set up achievable tasks while gradually increasing the complexity of those tasks (Bandura, 2004). For example, a supervisor would not set up a trainee for failure in a therapeutic relationship without helping the trainee to learn about her wants and needs from the therapeutic relationship.

Lastly, Bandura (1977) describes personal attributes, such as physical and emotional states, as a way for people to judge their abilities and either strengthen or weaken their self-efficacy. For example if people believe that their feelings of anxiety or depression are indications of personal weakness, they may have low self-efficacy about completing tasks in which these feelings arise (Bandura, 2004). Mood can affect a person’s judgment about self-efficacy, as positive mood may enhance perceived self-efficacy, and hopelessness can diminish it (Bandura, 1994).

Overall, Bandura believes that success is the result of a combination of “…a strong sense of self-efficacy to withstand failures coupled with some uncertainty (construed in terms of the challenge of the task, rather than fundamental doubts about one’s capabilities)” (Bandura, 1982, p. 123). Self-efficacy determines how fervently someone will aspire to and pursue a goal, how much effort will be used. It will also shape the expected outcome (Bandura, 2004). It is both directly and indirectly an influence on behavior, goal beliefs, outcome expectations of behavior, and how the environmental
factors are viewed (Bandura, 2004). Bandura noted that people with low self-efficacy tend to focus on personal inadequacies, anticipate problematic circumstances, and over-exaggerate difficulties, while individuals with high self-efficacy tend to invest greater effort and motivation to complete difficult tasks (Bandura, 1982).

Outcome expectations and goals are also important variables in increasing the likelihood of mastering an observed behavior. Outcome expectations refer to the likelihood of performing a modeled action which is believed to result in favorable consequences (Bandura, 1986). Bandura believes that people form beliefs about the consequences of a given action based on the perceived consequences and observation of other models (1986). Outcome expectations can refer to either external outcomes (“If I use the skills I have learned in class, I can perform well as a counselor with this patient”) or internal outcomes (“If I perform well with this patient, I will feel more confident in my ability as a counselor”; Schunk, 2000). Goals are important in skill acquisition because they “enhance learning and performance through their effects on perceptions of progress, self-efficacy, and self-evaluations” (Schunk, 2000). Goals act as motivators for persons to attempt behaviors with greater effort and persistence. It is important for goals to be challenging but attainable, specific and focused, and proximally achieved.

There appears to be some controversy in the literature about whether perceptions of self-efficacy are generalizable to multiple tasks or are a domain-specific construct (Bandura, 1986). According to Bandura, there are three levels of self-efficacy assessment. The most specific level refers to particular behaviors, thoughts, and feelings about executing a particular technique in a particular environment. The intermediate level of self-efficacy includes similar behaviors in similar environments, for example,
executing counseling techniques in a counseling session. The third and most general level of self-efficacy does not specify which activities or which environments the behaviors are performed (Bandura, 1986). Similarly, Schunk (2000) states that self-concept is a generalizable or collective self-perception of one’s abilities which is gained through previous experiences. On the other hand, self-efficacy as opposed to self-concept is domain specific, or in other words, refers to specific behaviors in a specific environment. As an example, a practicum counselor who believes that she is, overall, a helpful person who exemplifies the attitudes and behaviors of an effective counselor (self-concept) may not believe that she has the skills necessary to work with a grieving or obsessive-compulsive patient (self-efficacy). According to Lent, Hackett, and Brown (1998), the most general level of self-efficacy will not be as helpful as the most specific level of self-efficacy in predicting counselor affect and behavior in the counseling session with individual patients. The authors suggest that stronger predictions are possible when self-efficacy measures are tailored to situational self-efficacy within a specific environment and with a specific behavior (Lent et al., 1998).

Research on Counselor Self-Efficacy

Bandura’s theory of self-efficacy is the foundation for the construct of counselor self-efficacy (CSE). CSE, as defined by Larson and Daniels (1998), includes the beliefs one holds about his or her ability to effectively counsel patients. Larson and Daniels (1998) argue that counselors are expected to be efficacious in their counseling duties by constantly improvising with skills from a theoretical perspective. Larson and Daniels also state that when increased during the beginning stages of training, CSE enable trainees to be more persistent with difficult patients, more effective in their counseling skills over
time, and more likely to view anxiety in session as challenging versus debilitating (Larson & Daniels, 1998). These skills have been sub-divided into (1) task and content self-efficacy, which describes the perceived capabilities in defined helping skills and session management tasks, and (2) coping self-efficacy which reflects the management of more complex and challenging clinical circumstances (Lent et al., 2006). Lent and colleagues state that both task and content self-efficacy and coping self-efficacy are required for counselors to be efficacious in their work with patients. While to date there have been no research studies examining the impact of CSE on countertransference management, research has been conducted exploring the relation between CSE and counselor performance, anxiety, and training level of the counselor. This literature will be reviewed to underscore the significant impact CSE may have on countertransference management.

A basic tenant of CSE research is the assumption that CSE predicts stronger performance of counseling skills in session (Larson, Clark, Wesely, Koraleski, Daniels, & Smith, 1999). Research indicates that performance of these skills is directly related to confidence in one’s ability to apply critical thinking skills and empathy (Bradley & Fiorini, 1999). Bradley and Fiorini examined counselor education students and their practicum experience. They found that counselor’s ability to identify his or her skills as counselors and confidence in this ability to use these skills with patients directly influences the quality of counseling services they provide. Larson et al. (1999) used two common teaching techniques, videotapes of previous counseling sessions of professionals and role-play situations, to determine if a trainee’s ratings of success of the exercise would impact his or her CSE. Using a six-point Likert scale, 67 participants from pre-
practicum classes were asked to rate their success in either training exercise. Findings indicated that in the role-play situation, trainees’ CSE correlated significantly with how successful they rated their session. There was not a significant difference in scores for the videotaped treatment. The researchers (Larson et al., 1999) suggest that as counseling skills become more advanced, role-plays are good exercises to increase CSE.

*Anxiety management skills.* While the CSE literature acknowledges that emotions such as anger, hostility, attraction, frustration, and exhaustion can impact a therapist’s performance with patients, state and trait anxiety have been studied most frequently. Research has found that the beliefs about one’s ability to counsel others will affect the amount of anxiety trainees experience as well as how this anxiety may be interpreted, as either self-aiding or self-hindering (Larson & Daniels, 1998). Individuals with low self-efficacy will anticipate failures and focus on personal skill inadequacies while individuals with high self-efficacy will have greater motivation to persevere when challenges arise.

As theory would predict, a strong negative correlation has been found with both state and trait anxiety and CSE (Friedlander, Keller, Peca-Baker, & Olk, 1986; Larson et al., 1992). Friedlander et al. used state anxiety from the State Trait Anxiety Inventory (STAI) as a predictor variable with CSE as a covariate in examining counseling performance. Researchers found a significant inverse relationship between anxiety and performance and between anxiety and CSE suggesting that anxiety and CSE are important predictors of trainees' counseling-related behaviors (Friedlander et al., 1986). Larson et al. (1992) also used the STAI to examine the relation between CSE and anxiety. These researchers found that those counselors-in-training who had higher CSE had less state anxiety and trait anxiety.
Another study which examined counselor performance, anxiety and CSE is Larson et al.’s (1992) scale development research study. Researchers found that both master’s and doctoral level psychologists had higher self-efficacy than beginning practicum students. These results were found as researchers were creating a new CSE scale, the Counseling Self-Estimate Inventory (COSE). Five studies were conducted to assess the psychometric properties of the scale. Convergent validity for this measure found that CSE was related to greater self-esteem, less state and trait anxiety, stronger self-perceived problem solving effectiveness, more satisfaction with the pre-practicum experience, and better execution of counseling micro-skills. The micro-skills which are examined with this measure included items relating to countertransference behaviors on a subscale titled “Awareness of Values” (Larson et al., 1992). Example items include, “I am likely to impose my values on the patient during the interview,” “I feel that I will not be able to respond to the patient in a non-judgmental way with respect to the patient’s values, beliefs etc.,” and “I feel confident that I have resolved conflicts in my personal life so that they will not interfere with my counseling abilities.” These questions suggest that researchers believe a counselor’s CSE is partially determined by their self-reported ability to manage countertransference reactions and behaviors.

Lent, Hill, and Hoffman (2003) have also created a measure of CSE, after determining that the COSE has several measurement-related concerns. Their measure, the Counselor Activity Self-Efficacy Scales (CASES), will be used as a measure of CSE in the current study and will be reviewed more thoroughly in the next chapter. However, this measure, like the COSE, offers a subscale examining a counselor’s self-efficacy for managing countertransference reactions and behaviors titled “Relationship Conflict.”
Items from this subscale reflect “interpersonal tensions or potential conflicts between the patient and counselor” (Lent et al., 2003, p. 102). Example items include “working with a patient whom you have negative reactions toward (e.g., boredom, annoyance),” “working with a patient whom you find sexually attractive,” and “working with a patient who is dealing with issues that you personally find difficult to handle.” Again, it appears these researchers believe there is a correlation between CSE and countertransference thoughts, feelings, and behaviors.

An exploratory study by Nutt Williams, Judge, Hill, and Hoffman (1997) also studied counselors’ performance of counseling skills and anxiety by examining the types of reactions and awareness of reactions in beginning therapists have during counseling sessions. The authors hypothesized that beginning therapists would have a difficult time managing their reactions effectively in session and this would impact their performance in session and their ability to provide therapy. This study also examined therapists’ basic skills, anxiety, self-efficacy, and countertransference management using both qualitative and quantitative methods. There were a total of seven doctoral level pre-practicum trainees with a range of previous experience. Measures which were used in this study included the State Trait Anxiety Inventory to measure anxiety, the CFI-R to measure countertransference management, and the COSE to measure CSE. Quantitative analysis found that there was a significant decrease in anxiety between the first and last sessions of the semester. There also was an increase in countertransference management skills and overall performance between the beginning of the semester and the end of the semester. However, the increase in CSE was not significantly different between the beginning and end of the semester. Researchers note that these findings may be due to the small number
of participants. Qualitative analysis revealed therapists’ concerns included performance anxiety, concerns with therapeutic skills, role as therapists, and conflicts in the therapeutic relationship. Trainees also reported struggling with CSE in working with difficult patients and conflict which may arise in the therapeutic session. Specifically, feelings of anger, frustration, sadness, and nervousness were expressed when working with patients. The researchers of this study state that level of experience and developmental differences may impact a counselor’s CSE, anxiety, and countertransference behaviors.

Researchers have also examined medical students and their self-efficacy of psychiatry skills using a general self-efficacy questionnaire (Margolies, Wachtyel, & Schmelkin, 1986). Based on the idea that medical students have little exposure to the social sciences and counseling skills, they face anxiety about this area of medicine (Margolies et al., 1986). The researchers for this study created their own 10-item self-efficacy questionnaire which used a six-point Likert scale assessing perceived self-efficacy of “psychosocial and psychiatry-based medical tasks” (Margolies et al., 1986, p. 121). Their hypothesis that students’ perceptions of their psychiatry-based skills would improve between year one and two was found to be statistically significant with higher scores found at year two.

Johnson, Baker, Kopala, Kiselica, and Thompson (1989) examined CSE in master’s level counselors before and after a pre-practicum course. Fifty students participated and were divided into high and low CSE groups based on their scores from a measure created by the researchers for this study. These groups were then subdivided into either receiving counseling from doctoral level students or no counseling. A 2x2 factorial
design was used to examine the results which yielded increased CSE for but the high and low CSE groups over the course of the semester. Contrary to what other studies have found, Johnson and colleagues did not find a relation between performance and CSE. Additionally, there was no significant difference in CSE scores between students who received counseling and those who did not, suggesting that counseling may not reduce state anxiety when the students were in pre-practicum training. In terms of understanding this finding and its relation to countertransference management, and more specifically the self-integration component, further research is needed to understand this relation to CSE.

*Self-insight.* Another study which has examined CSE and counselor performance is a thesis conducted by White (1996) and referenced by Larson and Daniels (1998) and Kocarek, Talbot, Batka, and Anderson (2001). While this study could not be personally reviewed by the author, its findings seem to have particular relevance in understanding the relationship between CSE and countertransference management. According to Kocarek (2001), White attempted to predict success of counseling with training counselors by measuring CSE, self-esteem, self-awareness, and previous counseling experience. The two relevant measures to this study include the COSE which was used to measure CSE, and the Private Self-Consciousness Subscale, a part of the Self-Consciousness Scale created by Fenigstein, Scheirer, and Buss (1975). This subscale is said to measure how often a person is self-aware, defined as the level at which someone is aware of his or her thoughts, feelings, and motives. White found that all four measures (including CSE and self-awareness) were statistically significant predictors of counselor success as judged by their peers. These findings seem especially applicable to the self-
insight factor of countertransference management as there has yet to be research examining these constructs together.

*Conceptualization skills.* The training level of the counselor is another area of CSE research. One of the first studies in this area was conducted by Friedlander and Snyder (1983), whose findings confirmed the hypothesis that more training and practicum experiences would be correlated with greater self-efficacy. This study used a general measure of self-efficacy rather than a measure of CSE with 52 graduate students in counselor education, counseling and clinical psychology, and social work. Their educational levels included beginning practicum students, advanced practicum students, and interns. The study used four conditions of supervisor feedback to a participant’s stated opinion about how to handle a patient’s case on the basis of written background information. The four conditions were conflict (the supervisor recommended the opposite action of what the participant suggested), no conflict (the supervisor agreed with the participant’s plan for the patient), neutral (the supervisor indicated that both the participant’s and the opposite view were valid), and the control condition (no supervisor input). A participant’s self-efficacy was the covariate in this experiment rather than a dependent variable. However, there was a significant inverse relation between a counselor’s performance (comprehensiveness of participant’s plan for the patient) and anxiety and between anxiety and CSE, suggesting that CSE may impact the participant’s performance. The authors state that CSE increased with experience, however, the data were not presented in the article.

Using another measure of CSE created specifically for this study, Melchert et al. (1996) examined CSE among 138 therapists ranging from first-year master’s students to
professional psychologists. A significant correlation was found between CSE and both level of training and clinical experience. Findings suggest that “extended graduate training of doctoral programs in applied psychology provides increases in professional self-efficacy and competence that cannot be gained solely through acquiring additional clinical experience with a bachelor’s or master’s-level training” (Melchert et al., 1996, p. 642).

Similarly, Sipps, Sugden and Favier (1988) hypothesized a linear relationship between CSE and graduate level of training. Seventy-eight trainees participated in the study which found that there was a curvilinear relationship such that first-year students had a mean CSE score of 81.80, second-year students 77.34, third-year students 85.46, and fourth-year students 86.59. The researchers suggest that the decrease in CSE scores for second-year students may be attributed to feelings of failure at this point in their training. These findings are unlike that of other researchers (Friedlander & Snyder, 1986; Margolies et al., 1986; Melchert et al., 1996) who have found a linear relationship between CSE and training. Overall much of the CSE research has examined counselor performance, anxiety, and training level. Research findings suggest that in general, as CSE increases, anxiety decreases (Friedlander et al., 1986; Johnson et al., 1989; Larson & Daniels, 1998; Larson et al., 1992; Lent, et al., 2003; Margolies et al., 1986; Nutt Williams et al., 1997). Additionally, research has found that as self-awareness increases, so does CSE (White, 1996). Similarly, as practicum students have more training and develop their conceptualization skills their CSE also increases (Friedlander & Snyder, 1983; Melchart et al., 1996; Sipps et al., 1988). Included in many of the CSE measures are questions which relate to managing countertransference reactions suggesting that
researchers believe that an ability to manage countertransference reactions impacts performance of counseling skills and is vital to productive counseling. Examples include, “how confident you are in your ability to … remain aware of your intentions (i.e., the purposes of your interventions) during sessions,” and “to work effectively with a patient you find sexually attractive.”

The Current Study

Research has shown that countertransference reactions are the result of past or present unresolved conflicts and vulnerabilities (Gelso & Hayes, 2007). They may result in a deterioration of the therapeutic alliance (Myers & Hayes, 2006) as the therapist withdraws, avoids, or becomes overly-involved in the patient material (Cutler, 1958; Fauth & Hayes, 2006; Gelso et al., 1995; McClure & Hodge, 1987; Rosenberger & Hayes, 2002). For these reasons, managing these reactions is vital to the progress of therapy. While countertransference reactions may be inevitable, Gelso and Hayes (2007) theorize that there are five therapist characteristics which aid in managing these reactions: self-insight, conceptualization skills, empathy, self-integration, and anxiety management skills. What has yet to be studied is how these characteristics can be developed and refined in training counselors and psychologists. One step in doing so is understanding the relationship between countertransference management and two variables thought to promote management: emotional intelligence and CSE.

The purpose of this study will be to examine how emotional intelligence and CSE are associated with characteristics that have been empirically demonstrated to promote countertransference management. It is hypothesized that as emotional intelligence and CSE increase, so will one’s ability to manage countertransference reactions. Research in
emotional intelligence has revealed that emotions add unique information about the environment to our cognitions which helps to inform our thoughts, feelings, and actions (Damasio, 1994, 1999; Salovey et al., 2000). According to Salovey and Mayer (1997), emotions both inform and promote our intelligence through reflective regulation of emotion, understanding and analyzing emotions, emotional facilitation of thought, and perception, appraisal, and expression of emotion. These qualities make up the four-branch ability model of emotional intelligence. Research examining emotional intelligence indicates that it may benefit training psychologists and counselors as it is correlated with effective coping strategies (Austin et al., 2004; Brackett et al., 2004; Lopez et al., 2004; Louie et al., 2006), and psychological well-being (Ciarrochi & Godsell, 2006; Gohm, 2003; Gohm et al., 2001; Gohm & Clore, 2002). Emotional intelligence also appears to be moderately correlated with empathy (Brackett et al., 2006; Caruso et al., 2002; Ciarrochi et al., 2000; Mayer et al., 2000; Schutte et al., 2001).

CSE is another related variable which is hypothesized to correlate with the factors of countertransference management. CSE is defined as the belief one has about his or her ability to effectively counsel patients. The literature exploring CSE has yielded findings such that as CSE increases so does a counselor’s ability to perform counseling skills (Larson et al., 1992; Larson et al., 1999; Lent et al., 2003; Nutt Williams et al., 1997). Similarly, anxiety decreases among training counselors as CSE increases (Johnson et al., 1989; Larson et al., 1992; Larson et al., 1999; Lent et al., 2003; Margolies et al., 1986; Nutt Williams et al., 1997). Studies have also show that as trainees gain experience, CSE also increases (Melchert et al., 1996; Sipps et al., 1988; Snyder, 1983). Many of the scales which have been made to examine CSE, such as the COSE (Larson et al., 1992)
and the CASES (Lent et al., 2003), have included items which examine reactions and behaviors which may impact a counselor’s ability to work with patients. These items highlight the importance of countertransference management in effectively counseling patients.

It is hypothesized that:

a) There will be a direct relation between emotional intelligence and therapist characteristics that facilitate countertransference management such that as emotional intelligence increases, so will countertransference management.

b) There will be a direct relation between counselor self-efficacy and therapist characteristics that facilitate countertransference management such that as counselor self-efficacy increases, so will countertransference management.
Chapter III

Method

Participants

An a-priori power analysis was used to determine the required sample size based on two predictors (counselor self-efficacy and emotional intelligence), and a one-tailed analysis with alpha equal to .05. A small effect size would require 231 participants and a medium effect size would require 32 participants. An intermediate effect size of $r = .35$ was chosen, which will require 74 participant-pairs. The actual participants for this study were 48 complete supervisor-supervisee pairs.

Participants included doctoral and masters students in counseling, clinical psychology, and counseling psychology and their individual practicum or clinic supervisors. Participants were recruited from three training clinics and three counseling center universities in the north and mid-Atlantic regions of the United States. The sample of trainees had 11 (22.9%) identifying as male and 37 (77.1%) as female. With respect to ethnicity, 33 (68.8%) identified themselves as Caucasian, 1 (2.1%) as African American, 7 (14.6%) as Asian, 4 (8.3%) as Hispanic, and 3 (6.3%) people identified as Other. Their age ranged from 21 to 54 years old with a mean age of 29.64 years. Thirteen individuals (27.1%) said that a bachelor’s degree and 35 (72.9%) individuals said that a master’s degree was their highest level of education.

There was a total of 48 supervisors who participated in the study and supervised an average of one to two supervisees. There were no outliers detected among these pairs and therefore, all were used in analyses. The supervisors were either advanced graduate students in the same doctoral training program as the trainees, faculty in department, or
psychologists at the practicum site. It was required that supervisors meet with trainees on a weekly basis for at least one hour of supervision. It was also expected that graduate student supervisors would also participate in weekly group supervision which will be lead by a psychology professor for a minimum of one hour. The sample of supervisors who identified as male was 21 (43.8%) and 27 (56.3%) as female. With respect to ethnicity, 42 (87.5%) identified themselves as Caucasian, 4 (8.3%) as African American, 2 (4.2%) as Asian, and no supervisors identified as Hispanic. Their ages ranged from 27 to 68 years old with a mean age of 43.2 years. One supervisor (2.1%) said their highest level of education was a bachelor’s degree while 12 (25%) said a master’s degree and 35 (72.9%) said a bachelor’s degree was their highest level of education.

**Instruments**

*Demographic Form.* The Demographic Form (See Appendix A) for the counselor will ask participants to provide their age, gender, ethnicity, level of education completed, and months of previous counseling experience. The Supervisor Form (See Appendix B) will ask supervisors to provide their level of education completed, number of supervision hours with current supervisee, number of years of supervision experience.

*Countertransference Factors Inventory-R.* The Countertransference Factors Inventory Revised (CFI-R; Hayes, Riker, & Ingram, 1997) is a 27-item, five-point Likert-type supervisor-reported questionnaire that measures five elements of countertransference management: self-insight, anxiety management, empathy, conceptual skills, and self-integration (See Appendix C). The self-insight subscale measures a therapist’s awareness of his or her own feelings and understands the basis associated with these feelings (Van Wagoner, Gelso, Hayes, & Diemer, 1991). The anxiety management subscale measures a
therapist’s trait anxiety as well as state anxiety experienced in a therapy session (Van Wagoner et al., 1991). The empathy subscale measures the ability to intellectually understand another’s experience as well as affective empathy which is the ability to stand in another’s shoes (Van Wagoner et al., 1991). The subscale measuring conceptual skills measures is looking at a therapist’s ability to conceptualize the patient’s issues in the context of the patient’s past (Van Wagoner et al., 1991). Conceptualization ability is measured by a single item from the original CFI that demonstrated acceptable content validity (Hayes et al., 1991). Because single item subscales tend to lack reliability, this subscale was not included in the present study. Lastly, the self-integration subscale taps into a therapist’s general psychological health and the ability to differentiate oneself from others (Van Wagoner et al., 1991).

The items on the CFI-R are scored from 1 (“strongly disagree”) to 5 (“strongly agree”). Higher scores represent more of an ability to manage countertransference as evaluated by a supervisor. The Self-insight subscale contains eight items with an example being, “your supervisee…is aware of feelings in her/him elicited by clients.” A sample item from the Anxiety Management subscale (4 items) is, “your supervisee…is comfortable in the presence of strong feelings from others.” An example of an item from the Empathy subscale (4 items) is, “your supervisee…is perceptive in her/his understand of clients.” The Self-integration subscale includes 10 items with an example being, “the supervisee…is able to distinguish between the client’s needs and her/his own needs.”

Alpha coefficients for each of the subscales reflect adequate to good internal consistency: Self-Insight = .62, Anxiety Management = .80, Empathy = .80, and Self-Integration = .83, (Hayes et al., 1997). Research findings using the CFI indicate that
reputedly excellent therapists scored higher on all five dimensions than therapists in
general, thereby supporting the construct validity of the CFI (VanWagoner et al., 1991).
Content validity was established in a study by Latts (1996) in which 33 expert therapists
were asked to rate each of the 50 original items on the CFI based on importance to the
five factors of countertransference management (1 = not important, 5 = very important).
The questions which remained on the CFI-R had an average importance score of 4.3
(Latts, 1996). A modified version of the CFI was used to assess countertransference
management by male and female patients to either a heterosexual or lesbian patient-
actress. It was found that countertransference management ability was uncorrelated with
countertransference reactions in all but a few cases (Gelso, Fassinger, Gomez, & Latts,
1995).

Other studies have used the CFI to link countertransference management and the
ability to refrain from countertransference behavior (Gelso & Hayes, 2002). In a study by
Friedman and Gelso (2000), supervisors rated supervisees’ most current sessions using
the CFI. It was found that supervisees’ overall ability to manage countertransference was
negatively related to countertransference behaviors (Friedman & Gelso, 2000). In another
study by Rosenberger and Hayes (2002), a self-reported version of the CFI was used to
assess countertransference behavior. It was found that a therapist’s self-ratings were
positively correlated with a patient’s reports of session depth and working alliance
(Rosenberger & Hayes, 2002).

_Counselor Activity Self-Efficacy Scales (CASES)._ The Counselor Activity Self-
Efficacy Scales (CASES) was developed by Lent, Hill, and Hoffman (2003) to measure
counselor self-efficacy from a social cognitive perspective (See Appendix D). It is a 41-
item, 10-point Likert-type self-reported questionnaire. Items are scored from “No Confidence at all” (0) to “Complete Confidence” (9). The directions state, “Indicate how confident you are in your ability to use each of the following helping skills effectively, over the next week, in counseling most clients.” The measure is divided into three sub-domains that measure one’s perceived ability to: a) perform basic helping skills, b) manage session tasks, and c) negotiate presenting issues in counseling sessions.

In the first sub-domain, Helping Skills Self-Efficacy, there are 15 questions which assess helping skills as outlined in Hill and O’Brien’s (1999) counselor training model. This training model divides skills into three stages exploration, insight, and action which each have their own scale. Items from this section assess perceived listening ability, ability to use open questions, and ability to challenge the patient. Examples of questions include “attending (orient yourself physically toward your client),” and self-disclosures for insight (disclose past experiences in which you gained some personal insight).” The second sub-domain is titled Session Management Self-Efficacy and examines self-perceived ability to use the basic helping skills in specific counseling situations. There are 10 items on this scale including “respond with the best helping skill, depending on what your patient needs at a given moment,” and “building clear conceptualization of your patient and his or her counseling issues.” The third sub-domain, titled Counseling Challenges Self-Efficacy, examines counselors’ reactions to challenging counseling situations. Directions for this section are to “indicate how confident you are in your ability to work effectively, over the next week, with each of the following patient types, issues, or scenarios. (By ‘work effectively’ we are referring to your ability to develop successful treatment plans, to come up with polished in-session responses, to maintain
your poise during difficult interactions, and ultimately, to help the client to resolve his or her issues.)” There are 16 items in this third sub-domain which were modeled after Bandura’s theory of coping self-efficacy (Bandura, 1997).

The CASES was normed on 345 students (266 women) who were in either an advanced counseling skills undergraduate class \((n = 159)\), a master’s level counseling practicum \((n = 118)\), or various levels of doctoral training in counseling psychology \((n = 68)\). The participants were from five universities, ranged in age from 20 to 57 years \((M = 26.32, SD = 7.46)\), and were primarily European American (66%), African American (17%), and Asian American (9%).

The internal consistency estimates for the individual scales were found to all be acceptable. They ranged from .79 to .83 for the sub-domain Helping Skills Self-Efficacy \((\text{Exploration} = .79, \text{Insight Skills} = .85, \text{Action Skills} = .83)\), .94 for the sub-domain Session Management Self-Efficacy, and for the sub-domain Counseling Challenges Self-Efficacy, alpha coefficients ranged between .92 and .94 \((\text{Client Distress} = .94, \text{Relationship Conflict} = .92)\). These alpha coefficients provide evidence that the scales measures unitary constructs. The CASES total score alpha coefficient was .97.

Test-retest reliability was examined using a separate sample of 48 participants \((35 \text{ women, 13 men})\) over a two-week period. Findings indicated that scores were reasonably stable over the two-week period \((\text{Helping Skills Self-Efficacy} = .59 \text{ to } .71; \text{Session Management} = .76; \text{Counseling Challenges Self-Efficacy} = .66 \text{ to } .75; \text{CASES total score} = .75)\).

Convergent validity was examined using the Counseling Self-Estimate Inventory (COSE; Larson, Suzuki, Gillespie, Potenza, Buchtel & Toulouse, 1992) which has five
sub-domains: a) use of micro skills, b) attending to counseling process, c) dealing with difficult patient behaviors, d) behaving in a culturally competent manner, and e) being aware of one’s own values. Correlations between the CASES and COSE revealed strong relationships between scales which measured similar content (CASES Session Management Scale and COSE Micro skills $r = .64, p<.01$, COSE Process $r = .67, p<.01$; CASES Client Distress and COSE Difficult Client Behaviors $r = .61, p<.01$). The correlation between the CASES and COSE total scores was $r = .76, p<.01$. Discriminant validity was also examined and revealed only small to moderate correlations ranging between .19 and .30 between the COSE subscales titled “behaving in a culturally competent behavior” and “being aware of one’s own values” with each of the CASES subscales.

Lent et al. (2003) examined CASES scores during the first week of a second semester master’s practicum class and the 15th week using paired sample $t$ tests. Significant gains ($p<.001$) on every scale were found, suggesting that participants were reporting greater confidence in the three sub-domains (six scales) over the course of the semester. Increases in scores, as indexed by Cohen’s $d$ (Cohen & Cohen, 1983), ranged from .70 to .86 for scale scores, and .95 for the total score. Additionally, Lent et al. also examined self-efficacy scores as a function of counselor development level (number of years of previous helping-counseling experience). Participants were divided into three levels of experience, a) less than one year ($n = 65$), b) one to three years ($n = 97$), and greater than three years ($n = 77$). A multivariate analysis of variance found significant differences among the three groups’ self-efficacy scores ($F_{(12, 462)} = 4.34$, Wilks’s lambda $= .81, p<.001$) such that the two more experienced groups had greater self-efficacy scores.
compared to the participants with less than one year experience. Total score means were
\[ M = 5.36 \ (SD = 1.26) \] for participants with less than one year experience, \( M = 6.05 \ (SD = 1.13) \) for one to three years experience, and \( M = 6.61 \ (SD = 1.02) \) for participants with
greater than three years experience. The researchers concluded that counselor self-
efficacy increases with relevant helping-counseling experience.

*Mayer-Salovey-Caruso Emotional Intelligence Test V2.0. (MSCEIT)* Mayer,
Salovey, and Caruso’s (2002) assessment of performance-based emotional intelligence is
administered on-line and is made up of 141 items (See Appendix E). This yields two
Area scores (1. Experiential Emotional Intelligence and 2. Strategic Emotional
Intelligence) which are each made up of two Branch scores (1a. Perceiving Emotions, 1b.
Facilitating Thought, 2a. Understanding Emotions, and 2b. Managing Emotions). A total
emotional intelligence (EIQ) is also generated which describes one’s overall emotional
intelligence.

Overall, tasks vary in format and number of questions. The faces task has four
groups of questions, with five possible responses to each, and participants view a series
of faces and determine the emotion shown. The pictures task consists of six groups of
questions, with five responses each, and participants view a series of landscapes and
abstract designs and again, determine the emotion represented. In the sensations tasks,
respondents generate emotions and match sensations to these emotions. There are five
groups of three questions each. In the facilitation task, there are five groups of questions,
three responses each, in which the respondent judges the mood associated with specific
cognitive tasks and behaviors. In the blends task there are 12 items which require the
identification of emotions which can be combined. The changes task is 20 free-standing
items which requires the respondents to name the emotion which is an intensification of given emotion. The emotion management task is five groups of questions, four responses each, which require the respondents to judge the action that is required to get a desired emotional outcome for an individual in a story. Lastly, the emotional relationships task is made up of three item groups, three responses each, in which the respondent judges the actions that are most effective for a person to use to manage another person’s feelings (Mayer, Salovey, Caruso, & Sitarenios, 2003).

The MSCEIT can be scored in two ways, either general consensus (compared to a normative sample, n = 5,000) or expert consensus (compared to an expert sample n = 21). For the purpose of this study, the general consensus scoring model will be used. Raw scores are converted to standard scores (mean = 100, SD = 15) for interpretation. Gender, age, and ethnic differences exist in MSCEIT scores, such that women tend to score higher than men, older persons higher than younger persons, and Whites higher than Blacks and Asians on 14 of 15 scales. The MSCEIT manual does not speculate as to why these differences may exist.

The psychometric properties of the MSCEIT were drawn from a sample of 2,112 participants, 58% of whom were female, who had a mean age of 26.25 years (SD = 10.51) with about half the sample being college-aged. The group was educationally diverse with 0.6% not completing high school, 10.3% completing high school, 39.2% completing some college, 33.7% completing college, and 16.1% having a master’s degree or higher. The ethnic make-up of the sample of White, Asian, Black, and Hispanic persons was 59.7%, 34.0%, 3.4%, and 2.0% respectively. The majority of persons were from the United States (n = 1,240), with others from South Africa (n = 231), India (n =
194), the Philippines (n = 170), United Kingdom (n = 115), Scotland (n = 122), and Canada (n = 37). All testing was in English.

The test-retest reliability (at two weeks) for the MSCEIT total score was estimated to be .82 (n = 62), and split-half reliabilities for the total score and branch scores were estimated between .90 and .93. Internal consistency reliabilities for the eight task scores range between .64 and .88 (mean = .71). The correlation between the MSCEIT and other tests of intelligence is relatively low. For example, the correlation with the Vocabulary scale of the Wechsler Adult Intelligence Scale III was found to be .15 (Mayer, Salovey, Caruso, & Sitarenios, 2003). In another study (n = 97), the MSCEIT was found to have low to moderate correlations with the NEO-PI subscales of Neuroticism (.13), Extraversion (.04), Openness (.33), and Conscientiousness (.25), suggesting that the MSCEIT taps into something other than personality (Mayer, Salovey, & Caruso, 2002). Additionally, the MSCEIT appears to measure something different than other emotional intelligence measures such as the Bar-On EQ-i. The correlation between these two measures was r = .20 in a study by Brackett and Mayer (2003).

**Procedure**

The survey website for supervisors contained the overall directions of the study, an informed consent, a demographic questionnaire (See Appendix A), and the Countertransference Factors Inventory-Revised (CFI-R; See Appendix B). The survey website for supervisees contained the overall directions for the study, an informed consent, the demographic form (See Appendix A), and Counselor Activity Self-Efficacy Scales (CASES: See Appendix C). Upon completion of these questionnaires, a second link was presented, directing the supervisee to the publisher’s website of the Mayer-
Salovey-Caruso Emotional Intelligence Test (MSCEIT: See Appendix D). This measure contained its own directions.

Recruitment. Ninety-five supervisor-supervisee participant-pairs were recruited from training clinics and counseling centers in person, either during group or individual supervision with a participation rate of 49%. After expressing interest in the study, each participant received the same email containing an explanation of the study and what would be required of each participant. This email contained either the link to the supervisor or trainee on-line questionnaires. A reminder email was sent to participants if they have not completed the questionnaires after two weeks.

The study explanation explicitly stated that participation is completely confidential and voluntary, and would operate within APA ethical guidelines and the provisions established by The Pennsylvania State University Human Subjects Review Board. Trainees were be informed that graded material would not be affected by the decision to participate in the study. In order to protect their anonymity, participant pairs of supervisors and their supervisees were assigned numerical codes, and participants were instructed to not include their names anywhere on the survey. Participants were instructed to carefully read the instructions prior to completing the research surveys and to complete the research surveys in order. All research surveys were to be completed in one sitting. It was expected that trainee participants would take approximately one hour to complete surveys. It is expected that it would take supervisors approximately 15 minutes to complete surveys. Finally, all participants were given the option to request a debriefing letter upon the completion of the study. An incentive to participate was offered to each participant. Supervisors were entered in a drawing for one of two $20 gift certificates to
Amazon.com. Supervisees each received a $5 gift certificate to Dunkin Donuts or Starbucks.

*Data Analysis*

Prior to examining the proposed hypotheses, correlations between measured variables were examined for multicollinearity. The data were also assessed for univariate and multivariate outliers according to the methods outlined by Tabachnick and Fidell (2007). Multiple regression was used to examine the relationship between counselor self-efficacy and emotional intelligence (predictor variables), and supervisor-rated countertransference management ability (criterion variable). Due to the large number of dyads necessary for sufficient power, only the total scores for each instrument were examined for the primary analyzes.

Reliability analyses were then conducted on the total scores of the CFI-R, the CASES, and the MSCEIT. The responses on the CFI-R generated a standardized alpha for internal consistency of .95. This standardized alpha was similar to that reported by Van Wagoner et al. (1991). Reliability analysis of the CASES indicated a standardized alpha of .95, which is consistent but greater than Hill and O’Brien’s (1999) reported alpha of .97. The sample’s responses to the MSCEIT had an alpha reliability of .82 which is comparable to the reported internal consistency by Brackett and Mayer (2003) of .71.
Chapter IV

Results

Preliminary Analysis

Missing values in the data were handled by substituting the participant’s mean score for missing data when up to 10% of the individual’s data was missing for a scale. There were no more than two items missing for each participant. Level of significance was set at .05 for all statistical tests. Before conducting statistical analyses, the assumptions for each statistical test were checked. Data were first examined for univariate outliers and multivariate outliers according to recommendations by Tabachnick and Fidell (2007). No outliers were found among the data. All scales were also found to have acceptable levels of skewness and kurtosis. Means, standard deviations, skew, and kurtosis for each of the scales in the study are presented in Table 1.

Table 1
Descriptive Statistics for the Dependent Measures

<table>
<thead>
<tr>
<th>Variables</th>
<th>Mean</th>
<th>SD</th>
<th>Skew</th>
<th>Kurtosis</th>
<th>Cronbach’s Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>CFI-R</td>
<td>3.64</td>
<td>0.46</td>
<td>-.18</td>
<td>-.42</td>
<td>.95</td>
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<tr>
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<td>1.04</td>
<td>-.51</td>
<td>1.26</td>
<td>.95</td>
</tr>
<tr>
<td>MSCEIT</td>
<td>0.77</td>
<td>0.09</td>
<td>-.48</td>
<td>.35</td>
<td>.82</td>
</tr>
</tbody>
</table>

Note: CFI-R = Countertransference Factors Inventory-Revised; CASES = Counselor Activity Self-Efficacy Scales; MSCEIT = Mayer-Salovey-Caruso Emotional Intelligence Test.

Multicollinearity was assessed for the total scores of each of the dependent measures. The zero-order correlations are displayed in Table 2. There were no correlations that exceeded .70 among the three measures, which as suggested by Tabachnick and Fidell (2007), would make data analysis difficult. Countertransference management using the CFI-R was not significantly correlated with emotional
intelligence. It was, however, significantly correlated with counselor self-efficacy.

Emotional intelligence and counselor self-efficacy were not significantly correlated.

Table 2
Inter correlations Among Predictor and Criterion Variables

<table>
<thead>
<tr>
<th></th>
<th>CFI-R</th>
<th>CASES</th>
<th>MSCEIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>CFI-R</td>
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<td></td>
</tr>
<tr>
<td>CASES</td>
<td>.24*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>MSCEIT</td>
<td>.11</td>
<td>.10</td>
<td>1</td>
</tr>
</tbody>
</table>

Note: CFI-R = Countertransference Factors Inventory-Revised; CASES = Counselor Activity Self-Efficacy Scales; MSCEIT = Mayer-Salovey-Caruso Emotional Intelligence Test. * p < .05

Examining Data for Supervisor Effects. Dependency within the data was a potential confound as 11 supervisors had more than one supervisee. Twenty-one supervisors had one supervisee, seven had two supervisees, three had three supervisees and one supervisor had four supervisees. According to Kenny, Mannetti, Pierro, Livi, and Kashy (2002), when working with data from small groups, non-independence in the data may exist for a variety of reasons including common fate which can occur when supervisees have the same supervisors. An intraclass correlation coefficient (ICC) examines whether supervisees under the same supervisor are more alike than supervisees of a different supervisor. The ICC for countertransference management, the only measure completed by the supervisors in this study, was .11, which was not statistically significant. Due to the lack of apparent supervisor effects on CFI-R scores, data were treated as independent observations for subsequent analyses.

Primary Analysis

It was hypothesized that there would be direct relationships between supervisor-rated countertransference management and both counselor self-efficacy and emotional intelligence. Standard multiple regression was used to analyze these hypotheses. The
unidirectional hypothesis that self-efficacy would be related directly to
countertransference management was supported, $F_{(1, 46)} = 2.86, p_{(one-tailed)} < .05$, with
almost six percent of the variance accounted for ($r = .24$). The unstandardized regression
coefficient (B), the semipartial correlation ($sr^2$), $R^2$, and adjusted $R^2$ are included in Table
3. The second hypothesis that emotional intelligence would be related to
countertransference management was not confirmed $F_{(2, 45)} = .54, p_{(one-tailed)} = .233$. This is
displayed in Table 4.

Table 3
Summary of Regression Analysis Predicting Countertransference Management from
Counselor Self-Efficacy (N = 48)

<table>
<thead>
<tr>
<th>Variable</th>
<th>$R^2$</th>
<th>B</th>
<th>$\beta$</th>
<th>t</th>
<th>$sr^2$</th>
<th>Adj. $R^2$</th>
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<tbody>
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<td>CASES</td>
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<td>1.69</td>
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<td>.04</td>
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</table>

Note: CASES = Counselor Activity Self-Efficacy Scales.  
* $p < .05$

Table 4
Summary of Regression Analysis Predicting Countertransference from Emotional
Intelligence (N = 48)

<table>
<thead>
<tr>
<th>Variable</th>
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<th>$\beta$</th>
<th>t</th>
<th>$sr^2$</th>
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<td>.74</td>
<td>.11</td>
<td>-.10</td>
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</table>

Note: MSCEIT = Mayer-Salovey-Caruso Emotional Intelligence Test.

Additional Analysis

In order to better understand the relationship between the predictor variables,
emotional intelligence and counselor self-efficacy, and the criterion variable,
countertransference management, the correlations among subscales were examined. To
begin, the subscales of the CASES (Helping Skills Self-Efficacy, Session Management
Self-Efficacy, Counseling Challenges Self-Efficacy) were examined for their relationship
with the subscales of the CFI-R. These one-tailed correlations are displayed in Table 5.
<table>
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* $p_{(one-tailed)} < .05$

** $p_{(one-tailed)} < .01$
Using Cohen and Cohen’s (1983) recommendations, correlations from .10 to .29 are deemed to be small effects, from .30 to .49 as medium effects, and greater than .49 as large effects. In terms of the relationships between subscales of the CASES and CFI-R, all three subscales of the CASES were significantly correlated with the Anxiety Management subscale of the CFI-R. Additionally, it was found that Session Management Self-Efficacy was also significantly correlated with the Empathy subscale of the CFI-R, $r = .32$, $p_{(one-tailed)} < .05$. No CASES subscales predicted Self-insight or Self-integration.

Table 5 also shows the correlations between the CFI-R subscales and the subscale scores of the MSCEIT. As depicted, the Anxiety Management subscale of the CFI-R was related to two subscales of the MSCEIT, Facilitating Thought and Managing Emotions. The total score of the CASES, measuring counseling self-efficacy, was found to be correlated with two of the subscales of the CFI-R: Empathy, $r = .26$, $p_{(one-tailed)} < .05$, and Anxiety Management, $r = .47$, $p_{(one-tailed)} < .00$. These are also shown in Table 5.

**Level of training**

Another area of clinical interest was supervisees’ experience (months in graduate training) in relation to their ability to manage countertransference. This was a two-tailed analysis, as no predictions were made as to whether more training in a graduate counseling or psychology program would positively or negatively impact countertransference management as determined by a supervisor. It was found that “months in skills training” was not significantly correlated to the CFI-R total score or any of its subscales (Table 6).
Table 6  
*Intercorrelations Among Variables and Amount of Time in a Training Program (N = 48)*

<table>
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<th>MSCEIT</th>
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*Note:* Months = Months in a training program (supervisee); CFI-R = Countertransference Factors Inventory-Revised; CASES = Counselor Activity Self-Efficacy Scales; MSCEIT = Mayer-Salovey-Caruso Emotional Intelligence Test.

* p(two-tailed) < .05  
** p(two-tailed) < .01

Months in training, however, was significantly correlated with the CASES total score, Helping Skills Self-Efficacy subscale, Session Management Self-Efficacy subscale, and the Challenges Self-Efficacy subscale. This is displayed in Table 6 and Figure 1; however to make data more viewer-friendly, months in training has been converted into years in training in Figure 1.
Figure 1
*Years in Training and Counselor Self-Efficacy*

![Graph showing Years in Training and Counselor Self-Efficacy](image)

*Note:* 1 Years in Training = 0-12 months in training; 2 Years in Training = 13-24 months in training; 3 Years in Training = 25-36 months in training; 4 Years in Training = 37-48 months in training; 5 Years in Training = 49-60 months in training; 6 Years in Training = 61 and greater months in training.

Since the ability based model of emotional intelligence is thought to be trait based (Mayer & Salovey, 2002), it would be expected that experience with helping skills would not be significantly related to MSCEIT scores. This theory was disputed however as noted in Table 6, which illustrates that the MSCEIT total score was inversely related with months in a graduate training program $r = -.32$, $p_{(two-tailed)} = <.05$. The implications for this finding will be further discussed in the next chapter.
Chapter V
Discussion

Prior to this study, research had established the importance of acknowledging and understanding how countertransference may negatively impact therapeutic work (Ligiero & Gelso, 2001; Rosenberger & Hayes, 2002). Additionally, Hayes and Gelso (2007) have suggested that managing countertransference behaviors is possible when utilizing five therapist characteristics that aid in managing these reactions: self-insight, conceptualization skills, empathy, self-integration, and anxiety management skills. This study’s aim was to examine possible variables that may positively impact these therapist characteristics so as to increase one’s ability to manage countertransference. Counselor self-efficacy (CSE) and emotional intelligence were identified as possible means of doing so.

There were two hypotheses tested in this study. The first hypothesis stated that CSE would be directly related to therapist characteristics that facilitate countertransference management. The second hypothesis was that counselor emotional intelligence would be directly related to therapist characteristics that facilitate countertransference management. When examining the total scores of the measures, emotional intelligence did not appear to be significantly related to countertransference management while CSE accounted for a statistically significant, though modest, amount of variance. These findings on the surface seem to suggest that neither variable is a strong predictor of countertransference management ability in counselor trainees. However, when the correlations between subscales were analyzed, there were several notable findings which will be discussed below.
Counselor Self-Efficacy. In this study, CSE was measured using the CASES which has three subscales: helping skills self-efficacy, session management self-efficacy, and challenging clinical circumstances self-efficacy (Lent et al., 2006). Overall a small but significant relationship between countertransference management and CSE was detected, suggesting that as a trainee’s belief about his or her ability to be effective in therapy and with helping skills increases, so does his or her ability to manage countertransference reactions. When further analyses were conducted to examine the correlations between specific countertransference management factors and the three subscales measuring CSE, it became apparent that anxiety management was significantly correlated with all three aspects of CSE. Also, it was found that the empathy component of countertransference management was moderately correlated with session management self-efficacy.

The self-insight and self-integration subscales of the CFI-R were not correlated with any subscales of the CASES. These findings are consistent with Gelso and Hayes’ (2007) findings which, while conceptually appears to be related to countertransference management, this has not been found empirically. Previous research indicates that expert therapists view self-insight as especially important to managing countertransference (Hayes et al., 1991). However, research has found in studies by Gelso and colleagues (1995, 2002) that unlike other factors of countertransference management, self-insight has not consistently been correlated with greater abilities to manage countertransference reactions among training psychologists. This raises the question about what, if any, relationship exists between one’s ability to manage countertransference reactions and
their ability to reference a theory to understand their reactions to patients (Latts & Gelso, 1995)

The findings of this study confirm previous research which has found that trainees’ confidence in their ability to counsel others is associated with the amount of anxiety (both state and trait) they experience and how this anxiety is interpreted, as either self-aiding or self-hindering (Larson & Daniels, 1998). Studies have also shown that trainees often have concerns about their therapeutic skills, roles as therapists, and conflicts in the therapeutic relationship (Margolies, et al., 1986; Nutt Williams et al., 1997). The findings from the present study bring to light the importance of trainees feeling competent to conduct therapy and that it is associated with their ability to manage countertransference reactions.

Empathy, a second factor in managing countertransference, was also moderately correlated with CSE. This suggests that a trainee’s belief about her ability to counsel is directly related to how accurately she can understand her client’s experience without over-identifying with the client, and vice-versa. These findings are important as previous research has established that both countertransference feelings and empathy are the result of identification with the client (Peabody & Gelso, 1982). Empathy, however, allows the therapist to experience a part of what the client is experiencing, thereby maintaining the focus on the client. Countertransference emerges when this experience touches on an unresolved issue of the therapist (Peabody & Gelso, 1982), and as a result, over-identification can occur, leading to blurred boundaries and either too much or not enough distance in the therapy relationship.
If we view CSE as a predictor of one’s ability to manage countertransference reactions, it would benefit trainees to develop ways to increase their counseling self-efficacy. Social cognitive theory (Bandura, 1994), the theoretical basis of self-efficacy, identifies three components of learning which may be utilized in the supervision and training of students. The first, mastery experiences, also called performance accomplishments, requires persistent effort by the individual to succeed at a given task. As this happens over time, it acts as a buffer against failures and discouragement and may make constructive criticism easier to implement with the next client. Social modeling by the supervisor or classmate is another tool which may increase a counselor’s self-efficacy by watching how another succeeds at a similar skill. Lastly, persuasion of accomplishments, or reminding a trainee of previous successes, will likely increase self-efficacy and promote efforts to continue learning and developing counseling skills.

**Emotional Intelligence.** This was one of the few studies to investigate a performance-based model of emotional intelligence and its role in psychotherapy. Two significant correlations were found between the Emotional Facilitating and Reflecting Regulation of Emotion subscales of the MSCEIT and the Anxiety Management subscale of the CFI-R. Emotional facilitation involves the degree to which someone uses their emotions to improve cognition and memory (Mayer et al., 2002). Mayer and Salovey (1997) posited that using one’s emotional states may help to solve problems, reason effectively, and increase creativity. This subscale also examines one’s ability to recognize how emotions influence thought (for example, anxious emotions result in anxious thoughts). This study found that as trainees’ ability to recognize how their emotions influence decision making strengthens, so does their ability to manage anxiety.
The Reflecting Regulation of Emotion subscale measures how well one is able to tolerate and regulate one’s own emotions as well as those of others (Mayer et al., 2002). This includes the awareness, acceptance, and management of emotions which are both pleasant and unpleasant and the ability to tolerate these emotions. It is important to note that managing emotions entails utilizing them with thoughts rather than repressing them or attempting to rationalize them (Mayer, et al., 2002). It might be argued that this is the most important subscale of emotional intelligence in countertransference management. This subscale shows that by managing one’s emotions in session, this allows for greater command over reactions that are enacted with clients in session.

Again, this study found that emotional facilitating and regulation of emotion were significantly positively correlated with the anxiety management factor of countertransference management. Previous research suggests that emotional intelligence, and more specifically, awareness and regulation of one’s own and others’ emotions are essential to therapeutic work (Louie et al., 2006). Emotional facilitating requires the ability to utilize cognitive information as a means of influencing one’s emotions and understanding how this process works both in the therapist and the client. This study’s findings suggest that as a trainee is able to regulate his or her emotions and that of the client, he or she is also better able to manage countertransference-based anxiety.

There were two branches, perception, appraisal, and expression branch and the understanding and analyzing emotions branch were not found to be significantly correlated with countertransference management abilities. While hypotheses can be made about why these specific branches did not correlate to countertransference management abilities, it might be more helpful to examine if the MSCEIT as a whole is actually
measuring what it was intended to measure for this study. According to the user manual and previous studies, Mayer et al., state that the MSCEIT may be used in both clinical and research settings as well as educational, corporate, and correctional settings. While emotional intelligence may be important in each of these settings it also may be used differently. In this study, emotional intelligence was hypothesized to be a strength of a therapist as it would allow the therapist to perceive, facilitate, understand, and manage emotions as they pertain to both him or herself and the patient within therapy. While this may be true, it is questionable if a measure of emotional intelligence where “employees’ scores on emotional intelligence ability scales have been found to be related to their ability to excel in customer service positions” and “effective and smooth teamwork” (Mayer et al., 2002) is appropriate to also examine the complexity of emotions with the therapeutic relationship.

Level of Training. A last, but important set of findings from this study were a result of examining length of time in a graduate level program and its correlation with countertransference management, counseling self-efficacy, and emotional intelligence. Results indicated that level of training was moderately and directly correlated with CSE, moderately negatively correlated with emotional intelligence, and not significantly correlated with countertransference management.

Previous research has found a relation between level of training and countertransference management (Nutt Williams et al., 1997) across a semester for doctoral students such that anxiety significantly decreased between the first and last sessions while countertransference management skills significantly increased. The present study examined countertransference management scores at one time point and
compared scores to all other participants based on months in a training program. This cohort approach is methodologically different than the longitudinal study by Nutt Williams and may account for the finding that countertransference management was not correlated with level of training. The finding that countertransference management scores did not significantly change based on level of training also highlights the importance of addressing these factors at all levels of training including via post-licensure continuing education. Previous research (Hayes et al., 1998; Rosenberger & Hayes, 2002) has found that even master therapists frequently experience countertransference reactions in sessions. It is also important to remember that not all reactions stemming from countertransference are deleterious for the therapeutic relationship. Hayes et al. (1998) found that some manifestations of countertransference led to helpful identification with the client and compassionate understanding. Realizing that these reactions can be both positive and negative, it might be suggested that countertransference reactions be examined more closely in supervision to determine the outcome of countertransference reactions with each client.

This study confirmed several previous findings that CSE increases with graduate training (Melchert et al., 1996) but not necessarily in a linear pattern. Similar to findings by Sipps et al. (1988), this study showed a decrease in scores from the first to second years in training, which Sipps et al. hypothesized to result from feelings of failure at this point in students’ training. It might also be possible that during the second year of training, students are assigned more difficult clients who offer more challenges to therapeutic skills and session management, and decrease counseling self-efficacy. Training counselors may also have a richer theoretical understanding of
countertransference and countertransference reactions and how they impact work with clients. It is interesting that this is the second study which has found this decrease in counseling self-efficacy between first and second year students and may be worth further investigation via qualitative analysis.

Emotional intelligence and level of training is an area of this study in which the results seem somewhat inconclusive. The moderate negative correlation between emotional intelligence and months in training seems to raise more questions than answers, and it may be premature to draw conclusions about this relationship. Overall, the sample in this study scored slightly higher on the MSCEIT than the average of the normative sample (.77 compared to .70). This placed the sample overall in the “high average/competent” group. Ability-based emotional intelligence is thought to increase in complexity and depth with age and development (Mayer & Salovey, 1997), which somewhat contradicts these findings. It is difficult to know if the fact that these findings run counter to theory is due to the modest sample size or if there is a relationship that is yet to be understood in the current literature. In any case, the possibility has not been negated that emotional intelligence may benefit psychologists in their work with clients, especially from a theoretical perspective.

As the findings of this study show, two facets of emotional intelligence do positively correlate with anxiety management. Furthermore, it can be concluded from this study that emotional intelligence does not increase linearly during training and/or across the lifespan. The question of state or trait emotional intelligence might also need to be analyzed to determine how stable of a construct this is and if or how it may be taught to
counselors in training. Until these questions are answered, how to utilize emotional intelligence and measure it might be better questions to ask.

Limitations of the Study

As with many psychotherapy studies, sample size posed a significant obstacle to this study in terms of having sufficient power to detect modest effects. Participation in the study included 82 supervisors but only 52 supervisees (resulting in 48 complete pairs). This shrunk the potential sample size considerably. Possible reasons as to why supervisees did not participate include the length of time required to complete the MSCEIT or having minimal incentive to participate. It is also possible that at this stage in their education, students may not have wanted to answer questions about their abilities as counselors and/or did not want their supervisors to be doing the same. This does raise some questions about the self-selection process for those who did participate and agreed to have their supervisors answer questions about their countertransference management abilities. As a result, the external validity of the findings may have been compromised.

Of course, generalizability is a question that pertains to all studies in psychology and this study is no different. In terms of strengths, this sample was very well-rounded in representing a range of helping professions including students from clinical and counseling Psy.D. and Ph.D. programs, counseling masters, higher education masters, and counselor education programs. While data were collected from several institutions, it should be acknowledged that only those individuals who initially expressed interest to the recruiter were ever officially asked to participate and of those individuals, there were 82 pairs. With the participation rate of just over 50% for supervisees, it might be that these participants differ from their counterparts who did not participate in some way. How this
impacts the study is not exactly clear at this time; however with the range of participants
it seems these findings can be generalized to most helping professions for both master’s
and doctorate level trainees. Additionally, there may have been some limitation due to
demand characteristics on the part of the supervisor as surveys were confidential but not
anonymous. In future studies, it may be helpful to have a third part “honest broker” who
can keep the identity of those participating confidential from the primary investigator.

The foremost study limitation was the lack of an experimental design which
therefore did not allow for causality to be determined. However, manipulating any of the
variables in this study would take away from the ecological validity of the findings and
on one level would detract from what this study was attempting to capture: does a
counselor’s emotional intelligence or one’s own opinion of her strengths and weaknesses
potentially impact her ability to manage countertransference reactions?

Another limitation of this study was the inability to gain further knowledge about
the supervision experience for both the supervisor and supervisee. Due to constraints in
power and time on the part of the participants (the supervisee was already committing at
least 45 minutes to this study), it might have been helpful to understand how the dyad
views the supervision working alliance and determine if this would be a confounding
variable. If supervisors had an especially poor or strong alliance, this may sway their
view of the supervisee’s true ability to manage countertransference. Additionally, it
would be interesting to see how the supervisee would self-rate his or her ability to
manage countertransference and how closely this aligned with the supervisor’s ratings.
Hayes et al. (1997) examined just this but found a small, negative correlation between
trainees’ and supervisors’ ratings of countertransference management. In any case, this
certainly would offer fruitful information to the supervision pair to discuss in terms of expectations for developmental level and conceptualizing client interactions.

It is important to remember that this study did not take into consideration any input from clients on their perception of session depth, alliance, or the impact of countertransference behaviors on sessions. These are factors which have previously been studied and offer insight into what is occurring during the therapy session.

*Future studies*

This study was a first step in understanding how psychologists’ self-efficacy and emotional intelligence may impact their ability to manage countertransference reactions. Gelso and Hayes (1998; 2007) have laid the groundwork for understanding factors that are necessary to manage countertransference; this is the first study to better understand what variables may cultivate these five factors. Only one of the two hypotheses yielded a significant finding, however, several significant correlations were detected as data analysis examined the specific aspects of countertransference management. It seems that further research might best begin by replicating this study and adding a qualitative component to the study may fill in the gaps that quantitative research has left especially when attempting to understand the utility of the five factors of countertransference management and whether emotional intelligence and CSE may enhance these factors. It also might be suggested that a different measure of ability based emotional intelligence be used, especially one that is intended for social science research.

Based on the current study’s findings, a second tier of studies might then examine how we can increase students’ counseling self-efficacy to positively impact their countertransference management and specifically, how to manage anxiety in session. It
might also be helpful to better understand what other factors taught in practicum classes help students to increase awareness of countertransference and how to manage it in session with clients. Additionally, since the supervision relationship was not examined in this study, it is important to consider this relationship in addition to classes as a means of increasing counseling self-efficacy and awareness of one’s behaviors.
References


Appendix A

Demographic Form – Counselor / Supervisee

Please indicate answers below

Age:

Gender: Male Female

Ethnicity - Include All that Apply:
Black/African American Asian American/Pacific Islander Caucasian, Non-
Latino Latino/Latina Native American Other – please specify:

Highest Level of Education Completed:
Bachelor’s Degree Master’s Degree Doctoral Degree

Number of months/years of graduate training in counseling skills:

Number of months in supervision with current supervisor:
Appendix B

Demographic Form – Supervisor

Please indicate answers below

Age

Gender:    Male    Female

Ethnicity – Include All that Apply:
Black/African American    Asian American/Pacific Islander    Caucasian, Non-Latino
Latino/Latina       Native American       Other – please specify:

Highest Level of Education Completed:
High School Diploma    Associate’s Degree    Bachelor’s Degree
Master’s Degree    Doctoral Degree

Number of years of previous supervisor experience:

Number of months supervising current supervisee:
Appendix C

CFI-R Supervisor Form

Below are characteristics that your supervisee may possess to varying degrees. Please indicate the degree to which you agree that each statement is descriptive of your supervisee using the following scale:

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<th>Not Sure</th>
<th>Agree</th>
<th>Strongly Agree</th>
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My supervisee:
1. Is able to see things from the client’s point of view.
2. Is aware of feelings in her/him elicited by clients.
3. Is able to conceptualize her/his role in what transpires in the counseling relationship.
4. Possesses a stable sense of identity.
5. Is able to comprehend how her/his feelings motivate her/him while counseling.
6. Is comfortable in the presence of strong feelings from others.
7. Is able to distinguish between the client’s needs and her/his own needs.
8. Is aware of her/his personal areas of unresolved conflict.
9. Is perceptive in her/his understanding of clients.
10. Is able to restrain herself/himself from excessively identifying with client’s conflicts.
11. Is aware of her/his personal impact on others.
12. Is willing to consider herself/himself as an impediment to client progress.
13. Is comfortable being close to others.
14. Is able to sort out how her/his feelings relate to clients’ feelings.
15. Resolves her/his emotional conflicts.
16. Is able to recognize the boundaries between herself/himself and others.
17. At the appropriate times, is able to stand back from the client’s emotional experience and understand what’s going on with the client.
18. Is able to use her/his past experiences to understand clients.
19. Is able to manage her/his need for approval.
20. Is able to reflect deeply on her/his own feelings.
21. Is able to identify with the client’s inner experience.
22. Recognizes her/his own negative feelings.
23. Is comfortable with herself/himself.
24. Is aware of fantasies in her/him triggered by clients.
25. Is psychologically balanced.
26. Possesses a firm observing ego.
27. Does not become overly anxious in the presence of most client problems.
Appendix D

CASES

Instructions: The following questionnaire consists of three parts. Each part asks about your beliefs about your ability to perform various counselor behaviors or to deal with particular issues in counseling. We are looking for your honest, candid responses that reflect your beliefs about your current capabilities, rather than how you would like to be seen or how you might look in the future. There are no right or wrong answers to the following questions. Please fill in the number that best reflects your responses to each question.

Part I: Please indicate how confident you are in your ability to use each of the following helping skills effectively, over the next week, in counseling most clients.

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No Confidence at all  Some Confidence  Complete Confidence

*How confident are you that you could use these general skills effectively with most clients over the next week?*

1. Attending (orient yourself physically toward the client.)
2. Listening (capture and understand the messages that clients communicate.)
3. Restatements (repeat or rephrase what the client has said, in a way that is succinct, concrete, and clear.)
4. Open questions (ask questions that help clients to clarify or explore their thoughts or feelings.)
5. Reflection of feelings (repeat or rephrase the client’s statements with an emphasis on his or her feelings.)
6. Self-disclosure for exploration (reveal personal information about your history, credentials, or feelings.)
7. Intentional silence (use silence to allow clients to get in touch with their thoughts or feelings.)
8. Challenges (point out discrepancies, contradictions, defenses, or irrational beliefs of which the client is unaware or that he or she is unwilling or unable to change.)
9. Interpretations (make statements that go beyond what the client has overtly stated and that give the client a new way of seeing his or her behavior, thoughts, or feelings.)
10. Self-disclosures for insight (disclose past experiences in which you gained some personal insight.)
11. Immediacy (disclose immediate feelings you have about the client, the therapeutic, relationship, or yourself in relation to the client.)
12. Information-giving (teach or provide the client with data, opinions, facts, resources, or answers to questions.)

*How confident are you that you could use these general skills effectively with most clients over the next week?*

1. Direct guidance (give the client suggestions, directives, or advice that imply actions for the client to take.)
2. Role play and behavior rehearsal (assist the client to role-play or rehearse behaviors in session.)
3. Homework (develop and prescribe therapeutic assignments for clients to try out between sessions.)

**Part II : Instructions – Please indicate how confident you are in your ability to do each of the following tasks effectively, over the next week, in counseling most clients.**

1. Keep sessions “on track” and focused.
2. Respond with the best helping skill, depending on what your client needs at a given moment.
3. Help your client to explore his or her thoughts, feelings, and actions.
4. Help your client to talk about his or her concern at a “deep” level.
5. Know what to do or say next after your client talks.
6. Help your client to set realistic counseling goals.
7. Help your client to understand his or her thoughts, feelings, and actions.
8. Build a clear conceptualization of your client and his or her counseling issues.
9. Remain aware of your intentions (i.e., the purposes of your interventions) during sessions.
10. Help your client to decide what actions to take regarding his or her problems.
Part III: Instructions – please indicate how confident you are in your ability to work effectively, over the next week, with each of the following client types, issues, or scenarios. (By work effectively we are referring to your ability to develop successful treatment plans, to come up with polished in-session responses, to maintain your poise during difficult interactions, and ultimately, to help the client to resolve his or her issues.)

*How confident are you that you could work effectively over the next week with a client who...*

1. Is clinically depressed.
2. Has been sexually abused.
3. Is suicidal.
4. Has experienced a recent traumatic life event (e.g., physical or psychological injury or abuse.)
5. Is extremely anxious.
6. Shows signs of severely disturbed thinking.
7. You find sexually attractive.
8. Is dealing with issues that you personally find difficult to handle.
9. Has core values or beliefs that conflict with your own (e.g., regarding religion, gender roles.)
10. Differs from you in a major way or ways (e.g., race, ethnicity, gender, age, social class.)
11. Is not “psychologically-minded” or introspective.
12. Is sexually attracted to you.
13. You have negative reactions toward (e.g., boredom, annoyance.)
15. Wants more from you than you are willing to give (e.g., in terms of frequency of contacts or problem-solving prescriptions.)
Appendix E

Example MSCEIT Items

Branch 1 - Perceiving Emotions

What mood(s) might be helpful to feel when meeting in-laws for the very first time?

Not Useful

a) Tension   1  2  3  4  5
b) Surprise   1  2  3  4  5
c) Joy        1  2  3  4  5

Useful
Branch 3 - Understanding Emotions
Tom felt anxious, and became a bit stressed when he thought about all the work he needed to do. When his supervisor brought him an additional project, he felt _____. (Select the best choice.)

a) Overwhelmed
b) Depressed
c) Ashamed
d) Self Conscious
e) Jittery

Branch 4 - Managing Emotions
Debbie just came back from vacation. She was feeling peaceful and content. How well would each action preserve her mood?

Action 1: She started to make a list of things at home that she needed to do.
Very Ineffective..1.....2.....3.....4.....5..Very Effective

Action 2: She began thinking about where and when she would go on her next vacation.
Very Ineffective..1.....2.....3.....4.....5..Very Effective

Action 3: She decided it was best to ignore the feeling since it wouldn't last anyway.
Very Ineffective..1.....2.....3.....4.....5..Very Effective
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EDUCATION

Ph.D. in Counseling Psychology
The Pennsylvania State University, University Park, PA
Dissertation: Trainees’ Ability to Manage Countertransference: An Exploration of Emotional Intelligence and Counselor Self-Efficacy
Graham Endowed Fellowship, 2006 & 2007
Expected: August, 2010

M.S. in Clinical Psychology
Loyola College in Maryland, Baltimore, MD
Thesis: An Extension of Terror Management Theory: The Effects of Mortality Salience on Self-Esteem as Mediated by Spirituality Among Terminally Ill Cancer Patients
September, 2006

Bachelor of Arts, Psychology
Villanova University, Villanova, PA
Thesis: An Extension of Terror Management Theory: The Effects of Mortality Salience on Self-Esteem as Mediated by Spirituality Among Terminally Ill Cancer Patients
May, 2004

CLINICAL EXPERIENCE

Center for Counseling and Student Development,
University of Delaware, Newark, DE
Pre-doctoral Intern in Professional Psychology
August 2009-August 2010
- Provide crisis, individual, and group psychotherapy to university students with a range of issues including anxiety, depression, sexual trauma, grief, traumatic stress, and eating disorders. Interpret psychological and career assessments with clients with consideration for cultural, religious, and ethnic factors. Supervise master’s students in psychotherapy practicum.

The Meadows Psychiatric Center, Centre Hall, PA
Advanced Doctoral Practicum Student
July 2008 – December 2008
- Provided intensive individual psychotherapy at an inpatient psychiatric facility to adults with issues including PTSD, sexual trauma, co-morbid addiction, TBI, psychosis, personality disorders, and severe depression and anxiety. Led and co-led 1 to 2 groups per day on the adult and stabilization (long-term) units.

The Cedar Clinic, The Pennsylvania State University
Clinic Supervisor - Graduate Assistantship
Supervisor: Kathy Bieschke, Ph.D.
August 2006 – August 2008
- Managed daily function of clinic with 12 doctoral-level trainees and 30 master’s level trainees each with a caseload of 5-7 clients. Managed client crises, facilitating referrals and consulting with other offices on campus including judicial affairs, disability services, and the career center. Coordinated research in the clinic including analyzing data for annual reports and worked with researchers on data collection within the clinic ensuring IRB protocol was maintained.

RESEARCH EXPERIENCE

Center for the Studies of Collegiate Mental Health (CSCMH),
The Pennsylvania State University
Research Team Member
May 2008 – August 2010
- Analyze data from 130+ participating counseling centers regarding student’s mental health and their presenting issues. Assisted in developing The 2009 Pilot Study and Executive Summary which examined over 28,000 cases for current trends in college student mental health including the prevalence and severity of issues and their generalizability to counseling centers across the United States.

GRANTS AND AWARDS

- Dissertation Research Initiation Grant, 2009 - Faculty Council Committee on Research Policy and Graduate Studies, The Pennsylvania State University
- Excellence in Research Award, 2007& 2009 - Mid-Atlantic Society for Psychotherapy Research
- Graham Endowed Fellowship, 2006 - The Graduate School, The Pennsylvania State University