SUBSTANCE ABUSE COUNSELING: EXPLORING THE PATHWAYS OF THERAPEUTIC PROCESS

A Thesis in

Counseling Psychology

by

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Submitted in Partial Fulfillment of the Requirements for Degree of

Doctor of Philosophy

May 2006
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Abstract

This study investigated therapy process in substance abuse treatment. Therapists’ well-being, emotional reactions towards clients, and therapists’ recovery status were examined to determine if these variables predict specific process variables. In the present study, variables that comprise effective process were client reports of therapist empathy, the working alliance, session depth, and therapist credibility. Therapists (N = 51), who were surveyed from a national sample of board-certified substance abuse counselors, were asked to include one of their current clients (N = 40) as part of the study. Significant relationships were found between therapists’ emotional reactions to clients and client ratings of the working alliance and therapist empathy. Therapists’ well-being did not predict their clients’ ratings on any of the dependent variables. Furthermore, there were no differences between recovering and non-recovering therapists on any dependent variables, nor did recovery status interact with well-being to predict any of the dependent variables. The implications of these results for theory, research, clinical work, and training are discussed.
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Acknowledgements

My doctoral journey has been a family affair. It began with the birth of my son, and ended with the death of my grandfather. These pivotal events in my life clearly transcend the mind bending rigors ingrained in the doctoral training process. Throughout my training, my family and friends have provided critical support, sustenance, patience, flexibility, and grounding. I place doubtful likelihood on the notion that I would have been able to complete this harrowing and transforming experience without them. My wife Ann Marie has been my touchstone and confidant throughout, from the inception to the prize. She has experienced all the emotions, stress, and rewards this process elicits. This degree is as much hers as mine, and I love her for that. My children, AJ and Marina, have been extremely helpful and giving in their own right. They have kept me focused and humble, providing a constant reminder of what is really crucial and significant in this life. My mother is an anchor for me both personally and professionally, and I am appreciative of her guidance and strength helping to see this journey through its completion.

I have always been confused by the concept of a mentor. I have been blessed to have many influential bosses, supervisors, and friends throughout my career, but Jeff Hayes has given me a more cogent awareness of mentorship. He has been a conceptual guide, an astounding and patient editor, and has provided the perfect balance of gentle supporter and coach. He has been highly influential in my life and I consider him a mentor. One must choose their doctoral committee wisely, and I have done so. I wanted a blend of academicians, psychologists, and therapists, and I was quite fortunate to have found it all. Joyce Illfelder-Kaye is a sensitive and potent clinician, and I am a better therapist and person to have trained under her tutelage. Brandon Hunt makes me smile, and that is a
must for any doctoral committee, and her concise editorial and conceptual feedback has been greatly appreciated. Louis Castonguay stands out as a conceptual sage, bringing his craft of passionate and influential research experience contributing greatly to this final product. I would like to acknowledge all of my coworkers at the Penn State Psychological Clinic, who have all made this journey possible. Brian Rabian was my “silent advisor” throughout this process and I am grateful for his wisdom and friendship. I would also like to thank Benjamin Deweese, who was instrumental in preparing and stuffing hundreds of mailings that ultimately made an overwhelming survey design bearable.
Chapter 1: Study Overview

Psychotherapy research often examines three distinct variables with respect to their impact on therapy process and outcomes. These include the specific treatment approaches and types of interventions, the unique characteristics of clients, and the therapist delivering the service. The present study explored the unique contributions of the therapist in substance abuse counseling. This study posited that substance abuse therapists bring a phenomenological perspective to the therapy relationship that encompasses their personal histories, experiences, and characteristics.

In his seminal work examining appropriate questions to ask in process and outcome research, Paul (1968) captured the role of the therapist in his now famous quote, “In all its complexity, the question towards which all outcome research should ultimately be directed is the following: What treatment, by whom, is most effective, for this individual with that specific problem, and under which set of circumstances?” (p. 111). Paul specifically refers to the personal-social characteristics of the therapist and the physical-social treatment environment where the therapist and client come together, and in the case of the present study, the setting was substance abuse counseling. The present study was not an outcome study per se, yet it intended to examine the process of therapy with a substance abuse population, highlighting some of the specific therapist contributions.

In substance abuse treatment, there is ample research examining the unique treatment approaches, as well as thoughtful investigations regarding substance abusing clients and their impact on therapy process. While the research is relatively sparse on therapist variables in substance abuse treatment, variations in treatment efficacy are thought to be
greater among therapists who work with more difficult populations, and clients with substance abuse disorders have greater difficulty in many life functioning areas such as legal, health, employment, family, etc. (Najavits & Weiss, 1994). Substance abuse clients can present with an array of overt and covert defense mechanisms that make the process of therapy extremely difficult. Some noted defenses are overt behaviors such as anger and acting out, direct and personal confrontations, difficulty with adherence to ground rules, and covert defenses such as intellectualizing, avoidance, and helplessness (Imhof, 1991). These client characteristics can often evoke emotional and behavioral reactions in those who are charged with their treatment.

In the broader mental health and psychotherapy community, inexperienced therapists faced with substance abusing clients may often respond with negative, fearful, and avoidant reactions such as “They can’t get better,” “I don’t understand that area of work,” or “Alcoholics Anonymous is the main treatment for that” (Najavits, 2001). This is troublesome given the prevalence of clients presenting with substance abuse disorders in the general mental health profession (McCrady, 2001). There is, however, something unique about the substance abuse therapist that is often overlooked in substance abuse treatment research; many substance abuse therapists are themselves recovering addicts and alcoholics. That is, they have personally grappled with their own addictions, begun a personal recovery process, and have subsequently chosen to work with clients who are struggling with substance abuse. This places the substance abuse counselor in a unique position to be researched. It calls into question how a personal history of substance abuse problems affects a therapist’s ability in treating others with a similar condition. The
present study attempted to shed some light on the role of the substance abuse counselor as a helper, and as a therapist.

For many years, researchers have examined the efficacy of recovering therapists with respect to their non-recovering counterparts. This has proven to be a mostly fruitless journey yielding results that have been primarily equivocal between recovering and non-recovering counselors (Culbreth, 2000; Najavits & Weiss, 1994). While these analyses have shown little evidence of differences, there are equally compelling findings in the literature, namely that therapists often vary with respect to skills and outcomes in substance abuse counseling (Luborsky et al., 1985; McClellan et al., 1988; Najavits & Weiss, 1994; Project MATCH, 1998). While recovery status has not adequately predicted differences in outcomes, therapists in substance abuse counseling as a group have variable outcomes.

Independent of efficacy findings, there are many differences between recovering and non-recovering substance abuse counselors. Recovering counselors tend to be older, less educated, endorse a disease model of alcoholism more rigidly, are less flexible in treatment approaches, and tend to view professional training less favorably (Culbreth, 2000). Conversely, recovering counselors may be able to utilize their personal experiences for therapeutic gains. Recovering counselors may be able to form a unique therapeutic bond with clients, be an active role model for recovery, present as an expert in recovery processes, provide personal orientation to Alcoholics Anonymous, use language that is more understandable to the client, and more effectively convey empathy and hope (Blume, 1977; Lawson, 1982; McGovern & Armstrong, 1987; Peyton et al., 1980).

Substance abuse counselors in recovery are not only facing a challenging client population with complex needs, they are also simultaneously managing their own recovery
programs. Failure to maintain a personal recovery, lack of detachment, and over identification have all been found to be some of the most common causes of relapse amongst recovering counselors (McGovern & Armstrong, 1987), placing considerable pressure on the substance abuse therapist in recovery to maintain a sense of psychological equilibrium.

The present study, however, did not attempt to further a comparative outcome approach; instead it intended to explore variables beyond, or interacting with, recovery status. While being in recovery is certainly not a psychological deficit or problem, the quality of psychological well-being might alter a recovering therapist’s effectiveness. Thus, therapists in recovery who are mentally healthy may optimize their recovery status in therapy, being in a unique position to be empathic, develop alliances, be perceived as credible, and deeply explore client material. They may also model for their clients more effective resolution strategies for personal problems. Conversely, therapists in recovery who are more psychologically impaired might be limited in their ability to capitalize on strengths associated with their recovery status, thereby performing less effectively.

The present study will explore this potential interaction between well-being and recovery status and its possible impact on therapy process. Understanding specific pathways will hopefully shed some light on the role of personal recovery, and the corridors that lead to more effective treatment endeavors. The present study intends to examine the therapy process in substance abuse counseling by exploring specific therapist variables such as well-being and emotional reactions, and their potential relationship with therapy process. The specific variables of empathy, working alliance, session depth, and counselor credibility constituted effective process. To examine therapists’ perceptions of how
therapy is progressing, therapists’ well-being and emotional reactions were explored to see if these variables were related to therapists’ prognostic expectancies of their clients.
Chapter 2: Review of the Literature

People experiencing substance abuse disorders are an extremely heterogeneous group consisting of individuals with mild to moderate substance abuse problems such as the college student experiencing academic difficulties due to binge drinking patterns, to the individual experiencing significant medical, social, and legal consequences associated with his/her use. In mental health and medical settings, at least 25% of presenting clients are likely to have a substance use disorder (McCrady, 2001). This is a significant figure given that substance abuse treatment requires knowledge regarding the causes and associated diagnostic characteristics, as well as the known prevention and intervention strategies associated with substance use and abuse disorders. Furthermore, the majority of practicing clinicians are not always prepared to deal with the complex medical, social, emotional, and behavioral problems associated with substance abusing clients. For example, a survey of 1,200 psychologists found that 74% of those surveyed had no formal education or training in substance abuse, even though 91% reported to have practices that involved substance-abusing individuals (Aanavi et al., 1999).

Given the prevalence of co-occurring substance use disorders with mental health problems, health care organizations are increasingly requiring that clinical providers demonstrate competency in the treatment of substance use disorders prior to approval to deliver other, more general mental health services (Miller & Brown, 1997). Professionals working in mental health may have increased pressure to familiarize themselves with substance abuse assessment and treatment approaches, but they should also be aware of the complex psychosocial problems associated with substance abuse disordered clients.
Individuals presenting in drug and alcohol treatment facilities often experience an array of elaborate defense structures including denial, minimization, projection of blame, rigidity, black and white thinking, avoidance, rationalization, narcissism, and obsessive thinking (White, 1998). Given these complicated assortments of client characteristics, there is most likely considerable variability with respect to therapists’ comfort, experience, and attitudes towards substance abusing clients. With current interests and trends associated with therapist variables that impact specific treatment endeavors (Beutler et al., 2004; Horvath & Luborsky, 1993; Najavits et al., 2000; Norcross, 2002; Wampold, 2001), the substance abuse field provides a fertile environment to examine therapist characteristics that affect the therapeutic relationship, therapy process, and subsequent outcomes. While this fertile research environment may in part be due to the complex and challenging nature of substance abuse treatment, it is also quite promising given the long standing tradition of using counselors who have personal experience with addiction and recovery, who themselves implement much of the treatment services. Therefore, it may be argued that substance abuse counselors are themselves quite a heterogeneous group of individuals, ripe for further investigation.

The qualities of the therapist have long been of interest for many psychotherapy researchers, and there have been findings supporting that some characteristics of therapists would be more desirable and subsequently more effective in treatment outcomes (Luborsky et al., 1997; Miller et al., 1980; Wampold, 2001). However, in much of psychotherapy efficacy and outcome research, focus is often devoted to the specific treatment approach employed, or to specific client variables. Additionally, efforts are often made in psychotherapy clinical trials to control for any possible therapist effects through the use of
treatment manuals, supervision, adherence checks, etc. While these efforts are noble indeed, the literature consistently shows that variability in success rates often has as much as or more to do with the therapist rather than the type of treatment (Beutler et al., 2004; Luborsky et al., 1985; Wampold, 2001). Substance abuse treatment outcomes have been no different as many results have indicated that therapist differences have had sizable impact on clients’ substance use (Luborsky et al., 1985; McLellan et al., 1988; Miller et al., 1980; Project MATCH, 1998). To highlight these therapist effects in substance abuse treatment, the authors of Project MATCH (1998) note that “if these findings are so, then a vital task is the identification of processes and attributes that characterize more effective therapists” (p. 456). The current study posited that there is much to learn from substance abuse counselors and how they differ with respect to therapeutic processes and attributes. Additionally, this study set out to examine how some substance abuse therapists manage their own “unmanageable” backgrounds.

While many treatment approaches for substance abuse mirror other psychotherapeutic interventions, the substance abuse treatment field is quite different from other treatment settings. These differences are seen at the social, political, administrative, and philosophical levels of our society. For instance, most state and local public human service agencies have a distinct unit or branch devoted solely to the prevention and treatment of substance abuse problems, and laws governing substance abuse services with respect to confidentiality, privacy, and distribution of funding are unique and separate from other forms of human services. We do not see this focus and attention on any other specific psychiatric disorder such as depression, schizophrenia, personality disorder, etc. Another unique aspect of substance abuse counseling is the use of treatment staff who
themselves have suffered from substance abuse problems. Today, almost 40% of substance abuse treatment is delivered by recovering individuals (Banken & McGovern, 1992). Why does this phenomenon occur? Why do we not see recovering depressed individuals focused primarily on treating other depressed clients, or those who have suffered from obsessive compulsive disorder devoting their practice to the treatment of other obsessive compulsive individuals?

This study intended to examine therapist characteristics within the substance abuse field, and was aimed directly at the therapists themselves and the clients they serve. The present study first examined the extant literature with respect to the history of the substance abuse profession, and the use of recovering individuals’ providing treatment. This was be followed by a thorough review of the relevant empirical literature that has explored therapist characteristics in general as well as in substance abuse treatment. Collectively, these findings support the current design for a study that intended to shed some light on substance abuse counselors’ role in the therapeutic process.

**Paraprofessional Movement**

Use of recovering staff has been widely acknowledged and accepted in all forms of substance abuse counseling services. These individuals often identify themselves as “recovering” and therefore as no longer suffering from the grips of active alcoholism or drug dependency. The role of the recovering counselor as an integral component in the evolution of the addictions field and an important member of substance abuse treatment teams has been well documented (LoBello, 1984; McGovern & Armstrong, 1987; Shipko & Stout, 1992; White, 2000). According to Culbreth (2000), there has been a strong bias historically in favor of recovering counselors, based on the assumption that chemical
dependent clients will only listen to recovering counselors who have had experience overcoming an addiction. Valle (1979) addressed this potential bias when he found that many counselors in the substance abuse field feel strongly that only people who are recovering can fully understand what it is like to be alcoholic and that, therefore, they are most effective in counseling other alcoholics. “I know what it’s like because I’ve been there myself” is often stated as a unique qualification by recovering alcoholic counselors. This bias may be in part due to the prevalence of recovering counselors in the substance abuse field.

It is difficult to explore the phenomenon of recovering staff presence in treatment roles without examining the history and origins of the self-help movement. Alcoholics Anonymous (A.A) began in the mid 1930s and spawned one of the largest and most well-known self-help societies. The majority of substance abuse counseling and treatment programs today continue to adopt some form of 12-step philosophies into their general treatment modality and programming. It is important to explore the basic concepts and philosophies of Alcoholics Anonymous in order to shed some perspective on the impact and magnitude this organization has had on the recovering and treatment culture. Alcoholics Anonymous, as stated in their basic text often referred to as “The Big Book” (Alcoholics Anonymous, 1976), describes itself through its preamble as a fellowship of men and women who share their experience, strength, and hope with each other that they may solve their common problem and help others to recover from alcoholism. Recent estimates of membership taken from Alcoholics Anonymous World Services website and survey from the General Service Office (2002) found approximate total membership worldwide to include over 2,000,000 members with approximately 100,000 active meeting
groups. Given that the history of Alcoholics Anonymous and other similar 12-step groups such as Narcotics Anonymous were well established prior to the development of alternative substance abuse treatment approaches, it is no surprise that individuals who have benefited from these experiences would be looked upon to assist in helping others.

It is important here to examine the role of 12-step philosophy and the inclusion of recovering persons in substance abuse treatment profession. The 12th step in Alcoholics Anonymous is “Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs” (Alcoholics Anonymous, 1976). Awareness and engagement of this step and its inherent principle of “carrying the message” may be useful in examining the motivations of recovered individuals to participate in the treatment of others. Recovering counselors may feel compelled to reach out to others in need, especially since they may have experienced similar support when they were struggling. Regardless of motivations, which will be explored further in this study when the wounded healer paradigm is reviewed, the recovering individual has been involved in substance abuse treatment delivery since its inception.

As early as 1944 at the Yale Plan Clinic and in similar substance abuse treatment clinics, recovering counselors were incorporated into treatment initiatives to address the problem of substance abuse (Banken & McGovern, 1992). Since that time, other treatment modalities such as The Minnesota Treatment Model and the Hazelden Treatment Center bring into being a comprehensive, multi-dimensional (body, mind, spirit) approach to the treatment of alcoholism as a primary illness. This approach relies heavily on recovered non-degreed counselors in the delivery of treatment (Anderson, 1981). Between 1965 and
1975, virtually thousands of recovered alcoholics and addicts were enlisted in a wide variety of helping roles within newly emerging alcoholism and drug abuse treatment programs throughout the United States. They were often recruited directly out of treatment or out of local mutual aid societies. Once recruited, they worked as counselors, aides, psychiatric technicians, and house managers (White, 2000).

In order for these paraprofessionals to gain validation of their unique counseling capacities, they needed to develop and adopt state and national standards that would define their profession. The creation of the National Institute for Alcohol Abuse and Alcoholism (NIAAA) and the National Institute for Drug Abuse (NIDA) signaled the beginning of specialized training with an emphasis on counseling skills to meet the needs of alcohol and other drug dependent persons. By the end of the 1970s alcoholism and drug abuse counselors were providing most of the direct counseling and treatment services to alcohol dependent persons and their families. Counselors at this time were seen more as full time paid professionals who were distinguishable from members of voluntary organizations such as Alcoholics Anonymous (Banken & McGovern, 1992).

Theoretical and Empirical Literature Regarding Recovering and Non-recovering Substance Abuse Counselor

Theoretically, the literature suggests specific assets, as well as limitations, that recovering individuals bring to their treatment practices. One particular asset cited is that recovering counselors may have personal knowledge of the psychology and culture of addiction that is derived from their direct experience (White, 2000). This direct knowledge allows recovering counselors to convey empathy, hope, and warmth as well as disclose their own personal experiences. Recovering counselors may be able to form a unique
therapeutic bond with a client, challenge the client’s denial more forthrightly and forcefully, be an active role model and teach clients the day-to-day mechanics of remaining sober (e.g., providing personal orientation to A.A. and other mutual aid societies), and use language more appropriate and understandable to the client (Blume, 1977; Lawson, 1982; McGovern & Armstrong, 1987; Peyton et al., 1980). There are some noted limitations to being in recovery while attempting to serve in a therapeutic role. Professional helpers in personal recovery may be prone to experiencing inter-professional conflicts arising from differing views about the nature of addiction, reliance on personal expertise as a guiding theoretical orientation, and overextending themselves to compensate for their self-perceived lack of credentials (McGovern & Armstrong, 1987; White, 2000). Additionally, recovering counselors may experience role confusion and role conflict between mutual support group activities (i.e., 12 Step meetings) and professional counseling activities (White, 2000).

There have also been many specific empirical research efforts to explore the differences between the recovering staff and the non-recovering staff in substance abuse treatment facilities. Much of the literature seems to have dichotomized the recovering and non-recovering counselor into a comparative battle for efficacy and addiction treatment authority. The following review of this literature will begin with examining studies that have found some empirical differences in characteristics and outcomes between recovering and non-recovering staff. There will then be a review that subsequently finds few differences with respect to effectiveness between recovering and non-recovering staff.
Empirical Differences Between Recovering and Non-recovering Counselors

McGovern and Armstrong (1987) conducted a statewide (Texas) and national survey of alcoholism counselors. The researchers used a two part questionnaire that was developed by one of the investigators. Participants were asked to answer questions regarding demographics, attitudes towards counseling as a profession, attitudes towards alcoholism counseling, attitudes towards the recovering counselor and relapse, and common causes of relapse in recovering counselors. A total of 106 surveys were used in the statewide sample and 201 were used in the national sample (no return rate data given). Results indicated that recovering counselors differed from non-alcoholic counselors in that they were more often male, older, and had less education. However, they also found that recovering counselors were more likely to pursue drug and alcohol certification (state or national) than their non-recovering counterparts. Additionally, it was found that recovering counselors were less positive about the efficacy of non-alcoholic counselors and did not agree with their non-recovering peers about the need to gain additional professional and educational expertise (McGovern & Armstrong, 1987).

Interestingly, there were significant similarities when recovering and non-recovering counselors ranked the major common causes of relapse amongst recovering counselors. Failure to maintain a personal recovery program, lack of detachment from work, over commitment to work, discouragement, and over-identification with the clients were the five most commonly ranked causes of relapse among all those surveyed (McGovern & Armstrong, 1987). Some noted limitations in the study were that it used a non-standardized survey instrument, the distribution of the survey was not randomized, lack of distribution or return rate data, and there may have been duplication of participants in the
state (Texas) and national samples used (national sample was acquired during a conference held in Texas).

Stoffelmayr, Mavis, and Kasim (1998) surveyed over 500 substance abuse staff measuring demographics, adherence to 12-step principles, influence on decision making, treatment goal planning, and counseling techniques. They found that recovering staff were older, had less education, and worked more often in long term residential settings, rather than short-term or outpatient programs. They also found that recovering staff had fewer years experience working in substance abuse treatment and shorter tenure within the organization. Recovering staff also endorsed 12-step principles and practices more vigorously than non-recovering staff, and they also endorsed a wider range of treatment goals and reported using more varied treatment practices, when compared with their non-recovering counterparts. The authors noted that this finding is contrary to some previously held notions that recovering counselors may be more likely to strictly adhere to 12-step orientation exclusively, given their personal histories. Researchers actually found that recovering counselors endorsed a wider range of treatment goals and varied treatment practices. They also found that substance abuse treatment programs were often led by non-recovering, higher educated staff. Most administrators were non-recovering, tended to report spending more time on administrative duties, and rated their influence on both administrative and clinical decisions much higher than recovering staff (Stoffelmayr et al., 1998).

Lawson (1982) studied 28 counselors and 28 clients. Ten of the counselors in the study were identified as recovering. The study asked clients, randomly selected from each counselor’s caseload, to complete a measure of their counselor’s empathy. The measure
used was the The Barrett-Lennard Relationship Inventory (BLRI, Barett-Lennard, 1962). The study found that clients of recovering alcoholics reported higher total scores on the BLRI than did clients of non-alcoholic counselors. According to the author, “these results indicate that prior alcoholism in counselors was a significant factor in the quality of the relationship which existed between counselors and clients participating in the study” (p. 836). The study also found that counselors’ years of experience was not a significant predictor of BLRI ratings. The author noted that the counselor recovery status and empathy findings may have been due more to age, rather than recovery status since the recovering counselors were significantly older (Lawson, 1982). It should be noted that the sample size was small in this study and that there was only one measure of outcome used.

Similarly, Argeriou and Manohar (1978) found that positive changes in drinking behavior occurred significantly more often in young clients of recovering alcoholics than young clients counseled by non-alcoholics. The authors investigated 273 problem drinkers and seven alcoholism counselors (four in recovery and three with no substance abuse history). All problem drinkers were randomly assigned to the seven counselors in the study. Six dependent variables related to outcome were examined including months in program, number of sessions, drinking patterns at termination, recognition of problem, negative terminations, and mean number of weeks abstinent at termination. The study found that both counselor groups maintained their clients in treatment for comparable periods of time. While there was found to be a significant difference (improvement) in drinking outcomes among younger clients served by recovering counselors, this difference was not evident in clients over 35 years of age. The authors suggest that these findings support the contention that paraprofessionals (those in recovery) can be as effective as
professional counselors. The authors noted the small number of counselors studied, the narrow scope of variables examined, and the potential for bias as all variables were recorded from client files as limitations of the study.

Shipko and Stout (1992) set out to examine differences in personality characteristics of recovering and non-recovering drug counselors. The participants were 45 volunteers employed at drug and alcohol treatment facilities. Each participant completed a demographic questionnaire and the 16 PF personality instrument. While many demographic differences were found, such as recovering counselors more often being male, less educated, more frequently holding certification, and endorsing a disease model of alcoholism, there were no significant differences between recovering and non-recovering staff on the 16PF. The authors did, however, find some personality differences worth noting. With respect to the variables “education” and “certification” there were some significant findings on personality styles. Those participants with fewer than 16 years of education and no college degree were found to be more “concrete” and “tough minded” compared with those participants with more than 16 years of education who were found to be more “tender minded.” With respect to certification, those individuals with certification were found to be more “conservative” as opposed to those individuals without certification who were found to be more “experimental” in their behavior (Shipko & Stout, 1992).

LoBello (1984) set out to see if a counselor, when introduced as a recovering alcoholic, would receive a higher credibility rating by both substance abuse inpatient participants and university student participants. The study used an analogue design in which the independent variable of professional training (doctoral level vs. no training) and history of alcoholism (recovering vs. nonrecovering) were used to introduce the counselor seen by
participants in the videotaped therapy segment. Participants were then instructed to complete the Therapist Credibility Scale, which served as the dependent variable. The study included two separate experiments, differing only in participants as the first experiment used male alcoholic inpatients and the second experiment used male and female undergraduate students. The results for the substance abuse inpatient group revealed that they perceived professionally trained counselors as relatively more trustworthy and expert regardless of status as recovered alcoholic. In the undergraduate sample, the counselor received virtually identical mean credibility ratings when introduced as a licensed psychologist or as a recovering alcoholic. Therefore, the hypothesis of higher credibility ratings for counselors with history of alcoholism could not be accepted. LoBello (1984) points out that this finding further highlights the negligible role of personal experience of alcoholism in the perception of credibility and calls into question the adage “It takes one to know one.”

In a seminal review of variations in therapist effectiveness in the treatment of clients with substance use disorders, Najavits and Weiss (1994) found that when examining the recovery status of therapists, “after more than 50 studies of this sort, no significant difference among such categories of therapists have been found” (p. 680). Even in one of the most extensive and comprehensive clinical trials to date in substance abuse treatment, researchers found that client outcomes were unrelated to therapists’ self report of being alcoholic (Project MATCH, 1998). Project MATCH involved two independent matching studies, with one group of clients recruited from outpatient treatment ($N = 952$) and the other group of clients in aftercare treatment ($N = 774$). Clients were then randomly assigned to one of three manually guided treatment conditions (but not randomly assigned
to therapists). These treatment conditions included Twelve-Step Facilitation (TSF), Motivational Enhancement Therapy (MET), and Cognitive Behavioral Coping Skills Training (CBT). All therapists ($N = 80$), who were not randomly assigned to treatment conditions, treated at least one client. While there was no relationship between client outcomes and therapists’ report of alcoholism, it should be noted that the largest number of associations between therapist attributes and client outcomes was observed in the Twelve Step Facilitation condition. Interestingly, therapist education and years of experience was related to client outcomes only in the TSF condition, yet it was negatively related. Other therapist attributes in the TSF condition included higher need for aggression, lower need for achievement, nurturance, and lower conceptual level, all of which were related to client outcomes. Interestingly, nearly all (95%) Twelve Step Facilitation therapists reported having had a problem drinker or alcoholic in their immediate family, and 57% of these therapists identified themselves as recovering alcoholics whereas only one CBT and no MET therapists did so. Twelve Step Facilitation therapists were more likely to be certified and primarily employed as an alcohol/drug counselor. Additionally, TSF therapists more strongly endorsed disease model beliefs and were less likely to espouse psychosocial views of alcoholism (Project MATCH, 1998).

In a literature review that examined 16 empirical studies on the topic of substance abuse counselors with and without a personal history of chemical dependency, Culbreth (2000) concluded that client outcomes were essentially similar regardless of recovery status of the counselor. He also concluded that recovering and non-recovering counselors perceive problems in different ways, and that there were personality and attitude differences between recovering and non-recovering counselors. These findings include that recovering
counselors were found to be more rigid in their belief in the disease model of alcoholism, less flexible in treatment planning with clients, more concrete in thinking, and they had a less favorable view of professional training experiences. The author considered that a few key points were consistently highlighted in the literature: (a) clients do not perceive differences in effectiveness based on the counselors’ recovery status of the counselor, (b) there do not appear to be meaningful differences in treatment outcomes between recovering and non-recovering counselors, (c) there are differences in treatment methods and interventions used by recovering and non-recovering counselors, (d) recovering and non-recovering counselors perceive substance abuse problems in different ways, and (e) there are personality and attitude differences between recovering and non-recovering counselors that may impact treatment process. Culbreth (2000) points out that it is “time to begin a systematic collection of data examining differences in the counseling process and differences in how the therapeutic relationship is developed between recovering and non-recovering counselors” (p. 80).

Therefore, the examination of outcome differences between recovering and non-recovering has almost become a moot point. However, as the present study purported, the more meaningful question may be to examine how recovering therapists may differ as a group from their non-recovering counterparts with regard to therapy process. More specifically, what personality and attitude differences impact the treatment process, and in what ways? This study posited that personal recovery does not impede an individual from becoming an effective helper. But this does not necessarily mean all recovering therapists have achieved a sufficient resolution of their personal wounds and difficulties. This study further posited that those recovering counselors who have not adequately experienced
growth and resolution may be prone to poorer outcomes. Additionally, those recovering counselors who have experienced such personal growth may be in a position to provide unique and beneficial therapeutic experiences in their substance abuse treatment endeavors.

Variations in Therapist Effectiveness Beyond Recovering Status

Determinants of therapist success in substance abuse treatment have been explored in numerous empirical and theoretical investigations, and have produced some important findings. The most salient finding appears to be related to the notion that therapists do in fact vary with respect to skills and outcomes in substance abuse counseling (Luborsky et al., 1985; McLellan et al., 1988; Najavits & Weiss, 1994; Najavits et al., 2000; Project MATCH, 1998). This section will review some findings over the past few decades, and hopefully begin to shed some light on important directions for further investigation.

Luborsky et al. (1985) set out to examine what, at the time, had been a relatively unexplored area of therapist performance and determinants of therapist success. In the course of the study, the investigators found wide variations in the effectiveness of the individual therapists on virtually every outcome measure. The study looked at 27 therapists, 9 identified as psychotherapists and 18 as drug counselors. The therapies included manual forms of drug counseling, supportive-expressive therapy, and cognitive behavioral therapy. The study utilized multiple dependent measures and all treatments adhered to specific treatment manuals. Four specific determinants of therapist differences were explored; these included client factors, therapist factors, client-therapist relationship factors, and therapy factors (Luborsky et al., 1985).

With respect to client factors, the authors found no clear evidence that variability in client characteristics alone accounted for the consistent finding of differences between
therapists. Therapist qualities, measured in the study by independent evaluators, were found to be moderately related to outcomes. These therapist qualities included the therapist’s adjustment (psychological health), skill, and interest in helping clients. Client-therapist relationship qualities, which included the alliance, empathy, and understanding, were all positively related to outcome. Additionally, variability in therapy findings indicated that adherence to treatment manual, “purity” of treatment employed, and type of treatment were all related positively with outcome. Interestingly, drug counseling fared much worse when compared with supportive-expressive therapy and cognitive behavioral therapy. This finding was only observed on psychological outcomes, and not with respect to drug use. In sum, Luborsky et al. (1985) suggest that “the therapist is not simply a transmitter of a standard therapeutic agent. Rather, the therapist is an important, independent agent of change with the ability to magnify or reduce the effects of a therapy” (p. 609).

McLellan, Woody, Luborsky, and Goehl (1988) designed an experiment to see if the type of counselor impacted outcome for 61 opiate-dependent male veterans in a methadone maintenance treatment program. The experiment randomly assigned clients, who were unexpectedly dropped (due to therapist leaving) from their previous counselor’s caseloads, to the caseloads of four different counselors. The authors subsequently looked at five outcome measures spanning 6-month periods before and after case assignment. Specifically, investigators examined percentage of clients in the caseload employed or arrested, proportion of clients with positive urine results, proportion of clients prescribed ancillary psychotropic medications, and average methadone dosages. While there were only four counselors examined in the study, findings indicate marked and consistent
differences in outcome among the four counselors. There were no significant differences in demographic, background status, or prior treatment measures among the four caseloads at the time of transfer. Results also suggest that clients were not undergoing progressive improvement or deterioration during the pre-transfer period. Additionally, there were no significant differences with respect to qualifications or experience of the counselors, and while education and training may have had moderate effects, results were inconclusive.

The authors attempted to account for these differences by examining client records and counselor management practices to see if these counselor behaviors may have accounted for differences. Counselors who had the most positive effects on client outcomes appeared to document client treatment information in a more concerned, thorough, accurate, and organized fashion. They also found that more effective counselors adhered to program rules with their clients, utilized case management and referral techniques, and the majority of clients in these caseloads were seen for treatment more frequently. McLelllan et al. (1988) concluded that there are significant differences in effectiveness among counselors.

In an empirical review of clinician’s impact on the quality of substance abuse treatment, Najavits, Crits-Christoph, and Deirberger (2000) highlight some major findings and recommend methodological issues for future research. The authors contend that one of the most important findings from several decades of research on substance abuse treatment is that “clinicians are a key factor influencing treatment outcome and retention” (p. 2163). The authors examined the variable influences of clinician’s effect on treatment retention and outcome, professional characteristics, recovery status, adherence to protocols, countertransference, alliance, personality, beliefs about treatment, and professional practice issues. The authors summarized that while some of the easiest clinician variables to
measure were gender, race, age, training, and years of experience, these are often the least relevant to quality of service delivery. They suggested an examination of variables with more relevance to quality of care. These included empathy, ability to establish an alliance, emotional reactions to clients, professional demeanor and recordkeeping, ability to enforce clinic rules and make appropriate referrals to further care, and general beliefs regarding substance use disorders (Najavits et al., 2000).

These findings suggest that variations in therapist effectiveness impact client outcomes in substance abuse treatment. These findings are consistent with other psychotherapy research that finds the therapist to be a critical factor in the success of therapy (Beutler et al., 2004; Wampold, 2001). Whereas therapists’ demographics (age, sex, ethnicity) do not seem to impact treatment consistently, therapists’ attributes, skills, and behaviors such as psychological health, reactions towards clients, providing empathy, developing a therapeutic alliance, and maintaining professional demeanor do seem to affect outcome. Additionally, some therapist factors such as training levels and experience are inconsistent correlates with outcome yet may prove informative as their confounding contributors are reduced (Beutler et al., 2004). The current study set out to examine how some of these key variables may impact the therapeutic process. Specifically, this study examined the extant literature with respect to general therapist characteristics (therapist functioning, the wounded healer paradigm, countertransference/therapist reactions, therapist expectancy, and education level). Additionally, specific process variables that have been shown to impact outcome (working alliance, empathy, counselor credibility, and session quality) were reviewed.
Therapist Characteristics

Therapist functioning, not surprisingly, can encompass a broad range of definitions. In the context of psychotherapy research, therapist functioning can be attributed to a host of factors such as interpersonal skills, therapist burnout, therapist emotional disturbance, and therapist well-being (Beutler et al., 2004; Garfield & Bergin, 1971; McCarthy & Frieze, 1999; Valle, 1981). In a comprehensive review of the psychotherapy research, Beutler, Malik, Alimohamed, Harwood, Talebi, Noble, and Wong (2004) found that therapist well-being and freedom from distress were positively correlated with treatment benefits.

Garfield and Bergin (1971) examined 10 therapists’ MMPI results and found a trend suggesting that “healthier” or less disturbed therapists secured greater positive changes in their clients. Some noted limitations were that the 10 therapists used in the study were volunteers from an original group of 18 therapists, which significantly impacted an already small sample size. McCarthy and Frieze (1999) investigated the relationship between client perceptions of therapist use of social influence strategies (personal coercion, personal reward, expertise, compromise), therapist burnout (emotional exhaustion, depersonalization, reduced personal accomplishment), and clients’ perception of outcome (successful, satisfaction, effectiveness). Research participants were 131 students enrolled in an introductory psychology course who had seen a professional helper as part of course requirements. Results indicated that therapists who more frequently used personal coercive influence strategies and expert influence strategies were found to be less successful, had clients report less satisfaction with the therapeutic relationship, were viewed as less effective, and were more likely to have clients’ leave therapy due to dissatisfaction. Additionally, clients’ perceptions of therapists’ burnout were predictive of clients’
perceptions of outcome. The authors note as potential limitations to the study that results were based purely on clients’ perceptions and ability to recall accurately.

In a widely cited study on counselor interpersonal functioning, Valle (1981) set out to examine whether the quality of counselors differentially affects the results of treatment of alcoholism. Valle investigated four interpersonal skills of effective therapists, namely empathy, genuineness, respect, and concreteness. The author utilized 247 clients admitted for first time inpatient treatment, who were randomly assigned to 8 alcoholism counselors. The counselors were all recovering counselors with a variety of formal training and life experiences. Each counselor in the study had achieved at least 4 years of consistent sobriety. Counselor level of functioning was assessed by having counselors write responses to several stimulus statements designed to approximate therapeutic interactions. Responses were then assessed by two trained raters on interpersonal dimensions. Thirty eight outcome variables were examined through collection of hospital records and client surveys. Findings suggest that the level of interpersonal functioning may have a significant impact on outcome measures. The higher level of interpersonal functioning predicted beneficial outcomes on relapse rates, drinking rates, and relapse days (non abstinent days) at 6, 12, 18, and 24 months post treatment (Valle, 1981). The study utilized a large sample of clients and random sampling procedures.

Saarnio (2002) set out to replicate Valle’s (1981) findings on the impact of counselors’ interpersonal functioning on outcome. Saarnio examined whether counselors’ interpersonal functioning predicted therapy interaction and drop out rates in an outpatient substance abuse clinic. The study examined 66 clients assigned to 4 therapists. Interpersonal functioning (empathy, genuineness, respect, and concreteness) was measured
in a similar fashion to Valle (1981) using vignettes to be completed by therapists. The vignettes were rated by 20 trained social workers and undergraduate students. Interpersonal functioning of the therapists was correlated with clients’ ratings of therapy interaction and with dropout. The more positively the therapist’s interpersonal functioning was rated, the higher the clients’ ratings of interaction and the rarer the dropout rate. Saarnio (2002) noted that dropout rates were typically seen as a “client” problem often attributed to clients’ poor motivation levels. According to the author, this is an unnecessary excuse, for motivation is often created through the working alliance, that is, the interaction between the therapist and client.

While therapist functioning appears to have a significant impact on therapy functioning, there is not consistent agreement on how exactly therapist functioning is measured. To date, therapist functioning throughout the literature encompasses a broad range of therapist traits and behaviors. In the present study, therapist functioning was assessed by measuring therapists’ global mental health and well-being, in order to see if mental health status and well-being affected therapists’ therapeutic effectiveness. There are many possible factors that relate to variable rates of therapist functioning levels. One such factor may be imbedded in the personal lives and experiences of the counselors themselves.

Wounded Healer Paradigm

How do therapists’ own emotional well-being and personal experiences emerge in the therapeutic relationship? Is it important for therapists to be aware of their own history and how these experiences may affect their therapeutic functioning, the therapy relationship, and their capacity for healing? Substance abuse counselors in recovery are in a unique position to draw from their personal experiences for therapeutic gain. However, it could be
argued that not all recovering therapists are able to draw on these experiences in productive ways. What mediates this process? In order to examine this further, this review will examine a related construct, one that hopefully sheds light on the recovering therapist as healer.

To truly understand the nature, depth, and despair associated with suffering, one must have an acute awareness of one’s own experiences with suffering. As Hayes (2002) points out, “Regardless of one’s theoretical approach to therapy, it is a general truth that therapists’ overarching goal is to reduce human suffering” (p. 94). All too often, therapists and counselors are unaware of their own suffering experiences, which they may view as a liability when engaged in a healing relationship. Subsequently, counselors might ignore or disregard their own wounds, viewing them as compromising their ability to heal others. Indeed, many trust the ability of the healer to heal only to the extent that he or she is immune from any wounds (Remen et al., 1985). It may be difficult not only for the therapist to admit his/her wounds, but also for the client to accept or tolerate acknowledgement of the therapist’s wounds. Fleischer and Wissler (1985) captured this dynamic in their review of treatment approaches when working with therapists as clients. They purported that, “As therapists, we hesitate to admit and examine the emotional vulnerabilities which clients exquisitely tap, and as clients we do not want to recognize the special problems posed for our own therapists” (p. 587). Dismissal of therapist vulnerabilities may have specific consequences for therapists as well as their ability to be effective. As Grosch and Olsen (1994) point out, when therapists do not address their own wounds, they may be placing themselves at risk for increased susceptibility to burnout and distress. The authors stress that many mental health professionals with narcissistic
vulnerabilities and proneness to burnout give the impression that they are immune to weakness, illness, and wounds, and that their clients live in a completely different world. Such narcissistic vulnerabilities are fueled by a grandiose sense of self importance and uniqueness, thus creating a chasm between therapist/healer and client/wounded. The healers then develop into therapists-without-wounds and cannot release the inner healing factor in their clients. Moreover, their lack of effectiveness may contribute to personal feelings of inadequacy and inferiority, facilitating the process of burnout (Grosch & Olsen, 1994).

This perspective can be evidenced in the substance abuse field as many counselors are themselves recovering from alcoholism and addiction. The healing of these wounds is sometimes the very impetus for recovered individuals to pursue substance abuse counseling as a profession. As mentioned earlier in the paper, substance abuse counselors often employ philosophies learned from their own exposure to Alcoholics Anonymous. The 12th step of A.A., the one in which “we try and carry this message” to those who still suffer, highlights this perspective of utilizing one’s healing potential in the service of another. Yet as Bissel and Haberman (1984) point out, the A.A. member doing 12th step work and the professional treating or serving a client are doing quite different things, and the approach of each may well prove alien to the other. There is no exchange of money in 12th step work and it is understood that this effort is not designed solely to assist the newcomer but is also expected to help the helper maintain sobriety. While there may be a distinction between an A.A. member conducting 12th step work and a professional, it is possible that this line may be somewhat ambiguous when examining a wounded healer paradigm in this setting. The substance abuse therapist in recovery, therefore, often must navigate a complex field of
interpersonal relationships that may blur the lines between maintaining one’s recovery, helping other’s through 12-step fellowship work, and maintaining a professional practice standard. According to Miller and Baldwin (2000):

The nature of the helping relationship embodies the basic polarities inherent in the paradigm of the wounded-healer. These polarities ultimately relate to the vulnerability and healing power present in both healer and client. The wounded-healer paradigm presented here emphasizes the potential of the healer’s vulnerable or wounded side to release such power in the therapeutic relationship. (p. 244)

Thus the therapist’s vulnerabilities and wounded self are critical ingredients in establishing an effective helping relationship. In the context of polarities, there is a long history of the concept of the wounded-healer, which is stated clearly in the myth of Asclepius and Chiron. Asclepius is born of the union of the god Apollo and the mortal woman Coronis. During her pregnancy, Coronis is killed by Apollo’s sister, Artemis, when it is discovered that Coronis has been unfaithful to Apollo. While Coronis is on the funeral pyre, Apollo snatches Asclepius from her womb, and gives him to the centaur healer, Chiron, to raise. Under Chiron’s tutelage, Asclepius becomes the Greek god of healing. Paradoxically, Chiron suffers from an incurable wound originally caused by the poisoned arrows of Hercules, yet he is able to instruct many heroes in medicine and music. Thus, Chiron is a healer who is in need of healing (Graves, 1955).

Jung (1951) referred to the wounded-healer paradox when he stated that “only the wounded doctor can heal.” Thus, he is saying that the wounds of the healer must be acknowledged and utilized in the healing relationship. Additionally, according to Miller and Baldwin (2000), each client has an inner healer; however, when the intrapsychic or
inner healer does not act to heal the client, the sick person may seek an external healer. Not only does the client have a hidden inner healer, but the healer has a hidden inner client, and healer and client frequently cast mutual projections upon each other based on their hidden parts. In the training of Jungian analysts, each candidate is obliged to undertake hundreds of hours of personal analysis. It is assumed that the analyst is also a wounded healer, and must understand the nature of those wounds and his/her compensation lest they intrude unwittingly into the therapeutic relationship. Three questions are often asked in the training of analysts: What is the character of your wounding? How does your wounding affect your vision of self and others? What compensation must you make for those acquired reflexes so that they do not violate the therapeutic container? (Hollis, 1989).

If we are to examine the character of the wounded alcoholic or addict, it may become evident that the more the wounded addict is aware of his/her healing self, the more proficient he/she becomes at stimulating the inner healer within others. From all these considerations it appears that therapists’ acceptance of their own wounds through conscious awareness of their vulnerability contributes to a more effective healing relationship, which in turn enables clients to do the same and, thus, empower their own internal healers (Miller & Baldwin, 2000). Consequently, the strength of the therapeutic relationship may rest in part on the therapist’s conscious awareness of his or her vulnerabilities, which is connected to both recovering and non-recovering staff. As Strupp (1973) points out, “For a human relationship to become therapeutic, it is essential that the client has the capacity to benefit from what the therapist as a fellow human being, has to offer” (p. 2). This is extremely important because while it highlights the willingness and openness of the client, and his/her propensity for change, it is also assuming that the therapist has something to offer.
There is little empirical evidence for the wounded healer paradigm in the context of therapy, yet it would seem that the recovering counselor’s personal history is quite an important characteristic. This study set out to examine this paradigm through an analysis of the therapist’s well-being and other relevant therapist characteristics. If substance abuse therapists (in recovery or not) choose to utilize their previous wounds in the service of healing others, it could be argued that they must maintain a state of moderate well-being, function effectively with clients, and maintain some level of self awareness regarding their own histories.

*Countertransference/Therapist Reactions*

Therapists experience a wide range of emotional and behavioral reactions towards their clients. They may feel at times frustrated, bored, indifferent, or maybe even aroused. Therapists can express negative behavioral reactions towards clients such as being late, forgetting appointments, interrupting clients, or positive reactions such as extending the therapy hour, accepting calls at home, or given preferential treatment. Often, these countertransference reactions can affect the emotional distance between therapist and client (Hayes et al., 1998). Freud first defined countertransference as the analyst’s unconscious, conflict based reactions to the client’s transference (1910/1957). There have been other conceptualizations of countertransference over the years since Freud. One theory purports that countertransference includes all reactions that a therapist may have towards a client, which would include those that the client elicits. Some have argued that this theory, known as a totalistic definition of countertransference, goes too far and is too inclusive. For example, Hayes (2004) argues that this definition runs the risk of diverting attention away from the therapist and the effects of his or her own unresolved personal conflicts and
issues. Another definition of countertransference, and one that is more integrative, emerged from dissatisfaction with both Freud’s classical theory and the totalistic theory. This conceptualization of countertransference, developed by Gelso and Hayes (2002), defines countertransference as the therapist’s reactions to clients that are based on the therapist’s unresolved conflicts. “This perspective encourages therapists to take responsibility for their reactions, identify the intrapsychic origins of their reactions, and attempt to understand and manage them” (Hayes, 2004, p. 23). The current study conceptualized countertransference in this integrative manner.

It would be likely, then, that countertransference would be closely related with treatment outcomes, in a negative or inverse fashion. That is, the more countertransference observed in the therapist, the less likely it is that gains will be realized in therapy. Additionally, with respect to the management of countertransference it is believed that “if therapists fail to manage their own countertransference reactions, they place themselves at risk for acting out their own unresolved conflicts during the therapeutic work, thus failing to be of service to clients” (Gelso et al., 2002, p. 861). There has been some empirical evidence to support the premise that countertransference behavior can lead to poorer outcomes in psychotherapy (Gelso & Hayes, 2002; Gelso et al., 2002; Hayes et al., 1997), although these effects on treatment outcomes have been found to be inferential and not necessarily causal (Gelso & Hayes, 2002).

Additionally, many experts agree that knowledge of the self and introspective skills as a therapist can serve as a critical tool in managing countertransference (Hayes et al., 1997; Diemer, 1991). In fact, Hayes, Gelso, Van Wagoner, and Diemer (1991) developed the Countertransference Factors Inventory (CFI), which is divided into five subscales (self
integration, anxiety management, conceptualizing skills, empathy, and self-insight), each measuring an attribute that is theorized to be important in countertransference management. According to the authors, self integration refers to therapists’ intact character structure, implying a sense of stability and wholeness. Anxiety management refers to when the ego calls upon defense mechanisms to avert or diminish experiences of anxiety, thereby managing countertransference more effectively. Conceptual skills refer to therapists’ ability to draw upon theory for guidance in their work when examining client dynamics, thus minimizing potential distortions. Empathy refers to abilities that allow therapists to focus on clients’ emotions and needs, despite when they might be pulled in different directions. Self-insight refers to the awareness of therapists’ motivating forces behind their thoughts, feelings, and behaviors that impact therapy. The authors found, through a survey of prominent authorities on countertransference, that these five factors are considered to play a central role in the management of countertransference. Hayes et al. (1991) surmised that these factors, representing therapists’ skills and personality attributes, are more often reflected in the work of healthy, self integrated therapists. The next logical step then would be to find a relationship between therapists’ management of countertransference and the subsequent impact on treatment outcomes.

Hayes et al. (1997) sought to see if counselors’ management of countertransference impacts the outcome of treatment. In order to measure countertransference, they utilized an abbreviated version of the Countertransference Factors Inventory (CFI), as well as the Countertransference (CT) Index. The Countertransference (CT) Index, designed to be completed by counselors and supervisors immediately after sessions, is a single Likert type measure indicating the extent to which counselors’ in-session behavior was influenced by
countertransference. They examined 20 counseling dyads and utilized CFI ratings from the counselors’ previous supervisors. The authors found that previous supervisors’ ratings of counselors’ empathy and self integration were found to relate negatively to counselors’ countertransference behavior. Additionally, they found that countertransference behavior was unrelated to treatment impact in successful counseling dyads but was strongly related to treatment impact for moderately successful and unsuccessful cases. Hayes et al. (1997) noted limitations of the study including questionable construct validity of instruments, small sample size, and possible Type I error (multiple analyses conducted).

Gelso, Latts, Gomez, and Fassinger (2002) also utilized the Countertransference Factors Inventory (CFI; Hayes et al., 1991). Gelso and his colleagues found that a CFI total score was significantly positively correlated with all ratings of client outcome. Findings suggest that therapists who manage their anxiety levels, maintain appropriate emotional boundaries, and are able to conceptualize therapeutic dynamics between therapist and client, are more likely to facilitate client growth and improvement. The authors note that generalizability is limited due to low sample size, use of trainees (vs. experienced therapists), and lack of client report for outcome measures. Outcome data was provided by the Client Functioning Level Scale (CFLS), a Likert type measure in which therapists rate the general psychological functioning of clients (Gelso et al., 2002).

These findings are important given the present study in that therapists working in substance abuse may experience unique and highly personal unresolved conflicts that may impede their ability to function effectively as healers. Given the inherent difficulties when working with this population, one might assume that counselors working in substance abuse treatment would be more susceptible to stressors such as burnout, apathy, and other
effects of countertransference. In fact, Imhof (1991) posited that negative countertransference may be more easily triggered with substance dependent clients than with other clients. According to Rodriguez de la Sierra (2002), clients in substance abuse treatment can oscillate between seeing the drug as a helpful friend and being persecuted by it, thus producing enormous aggression acted out towards themselves, as well as the therapist. Given high rates of relapse, treatment resistance, and recidivism in substance abuse treatment, clients present significant challenges for therapists, which can provide rich and fertile ground for negative countertransference to emerge.

Negative countertransference toward substance dependent clients often include viewing them as outcasts, manipulative, or deserving special indulgence due to their sometimes severe psychosocial histories. According to Imhof (1991), effects of such negative countertransference reactions include indifference to the client’s complaints; cynicism; assuming the client to be a liar; hostility, a wish to control the client; “slippage” in ground rules of treatment, such as the therapist’s chronic lateness, missed sessions, or laxity in enforcing limits; boredom; over-solicitousness; premature ending of treatment; withdrawal or burnout; and intense or unstable feelings about the client.

There is empirical support that therapists’ negative countertransference is often triggered by the client’s diagnosis. According to Brody and Farber (1996), client diagnosis relates to therapist ratings of countertransference reactions. The authors found through a survey of graduate students and psychologists that countertransference reactions varied significantly as a function of client diagnosis. Work with depressed clients was associated with mostly positive countertransference (nurturing feelings, compassion, and empathy), while work with clients with borderline personality disorder was associated with a
predominance of negative countertransference reactions (irritation, frustration, and anger). Additionally, they found that working with schizophrenic clients evoked the highest perceived need to refer the client elsewhere, evoking countertransference reactions of anxiety, hopelessness, and a sense of challenge (Brody & Farber, 1996). A consistent theoretical and empirical finding in countertransference research is that clients often illicit significant affective and emotional reactions from their therapists, and that these reactions can have both positive and negative consequences.

Therapists’ emotional reactions and responses to substance abuse clients have long been hypothesized to impact treatment, but have rarely been studied (Najavits, 2000; Najavits et al., 1995). One study that did examine this specific topic was conducted by Najavits et al. (1995). Therapists in the study completed a measure called the Rating of Emotional Attitudes to Clients by Therapists (REACT), which is a 40 item self report measure in which therapists rate their emotional responses to specific clients. It was found that clinicians became more negative over the course of six months of treatment after previously having positive views of their clients. The study also identified four factors in clinicians’ emotional responses, three of which were negative: conflict with oneself over the degree to which one is performing adequately (e.g., feeling confusion and stress, and doubting one’s competence), conflict with the client (e.g., power struggles, feeling manipulated), and a focus on meeting one’s own personal needs (e.g., for financial, sexual, or intellectual gratification). A fourth factor contained only positive items (e.g., feelings of empathy, tolerance, and affection; Najavits et al., 1995). The authors suggest that relating such findings to treatment outcome would be a logical next step.
In sum, therapists’ ability to manage negative reactions towards clients can have an influence on the quality and outcome of treatment endeavors, especially when clients have challenging problems. This is especially true in substance abuse counseling and may be more true for the substance abuse counselor in recovery, given that the client may serve as a constant reminder of the therapist’s troubled past (Imhof et al., 1983).

**Therapist Expectancy**

Both therapists and clients often have certain expectations regarding the process and outcome of therapy. Clients may bring to the therapeutic encounter their beliefs regarding their capacity for growth and improvement, as well as their expectations of counseling to provide relief. The therapist may too have certain expectations of the client based on the client’s presentation, as well as the counselor’s beliefs, attitudes, and experiences. Frank and Frank (1991) make reference to this process in their review of the placebo response, and conclude that physicians’ ability to inspire expectant trust in a client determines, at least partially, the success of treatment. The authors note that psychotherapy can be highly influential, and subsequently the client will typically accept the conditions implicitly or explicitly set by the therapist.

In a classic study on expectancy in a school setting, Rosenthal and Jacobson (1966) found that teachers’ expectancies had significant effects on students’ performances, as well as their IQ scores. Teachers were led to believe that certain students (randomly assigned) would be “academic bloomers” based on the results of an achievement test, when no test was actually given. Those students in the experimental group, labeled as “academic bloomers,” showed significantly higher IQ score gains at the end of the study. Additionally, those same students were rated by their teachers as more intellectually
curious, happier, and in less need for social approval. The authors suggested that teachers’
expectancies may have resulted in differential treatment of those students who were
believed to possess greater potential, thus impacting the students’ performance.

Therapists are often faced with specific client presentations that may affect their
expectancies during the early stages of psychotherapy. These early expectancies may be
influenced by clients’ affective presentations (defensive, hostile, apathetic, avoidant, etc.),
client records (previous resistance to treatment, leaving treatment prematurely, extensive or
chronic histories, etc.), or client cultural characteristics (age, gender, ethnicity, SES, etc.).
Expectancies about psychotherapy can include beliefs about the duration of treatment, the
process of therapy, and the associated outcome of treatment (Joyce & Piper, 1998).

Effects of expectancies in substance abuse counseling were assessed by Leake and King
(1977) by creating conditions for counselors, who were falsely led to believe that certain
clients would be expected to show “remarkable recovery” during the course of treatment.
Counselors were told that predictions were based on clients’ results of a specifically
designed psychological personality test for the hard-core alcoholic. These “high alcohol
recovery persons” were randomly assigned and had no significant differences (ages, habits,
socioeconomic backgrounds) from their control counterparts. At the end of the study,
“high alcohol recovery persons” were rated by their respective counselors as being more
motivated, more punctual, more attractive, more cooperative, better able to remain sober,
and generally showed better recovery. Additionally, outcome measures revealed that “high
alcohol recovery persons” were more successful in finding jobs, reported fewer “slips,” and
evaluated their experiences with the program as more beneficial. Clients in experimental
and control conditions were also asked to rate their experiences with fellow peers in the
study. Interestingly, clients held more favorable evaluations of the “high alcohol recovering persons” with respect to preferences in social activities, participation in discussion groups, and peer evaluations of recovery skills. This was an intriguing and unexpected finding given that client participants were not made aware of identified “high alcohol recovering persons.” Findings indicate that clients in the control group did not show similar progress with respect to counselor, self, and peer evaluations, and they were more likely to terminate treatment (Leake & King, 1977).

In one study (Joyce & Piper, 1998), client and therapist expectancies were strongly associated with the development of the therapeutic alliance (accounting for 16% - 40% of alliance variance), but only moderately related with treatment outcomes (accounting for 8% of outcome variance). Martin et al. (1977) examined 19 therapists’ client specific expectancies of 84 adult schizophrenic inpatients. Prognostic expectancy was measured by therapists approximately 2 weeks after each of their clients were assigned (semi-random) to them. Measures of client adjustment were assessed at discharge and again at 9 month follow up. Therapists’ client specific expectancies were correlated significantly with 12 of the 15 adjustment measures at discharge (.21 to .51), and were correlated significantly with all measures of client adjustment at 9 month follow up (.25 to .39). The results supported a predictive interpretation of the link between therapists’ expectancies and treatment outcome for their clients. Expectancy can have significant implications in the process and outcome of psychotherapy, and has been found to account for approximately 15% of all outcome variance in summated psychotherapy research (Lambert & Barley, 2002). The present study set out to examine therapist expectancy, and its role in the quality of therapeutic process.
Education Levels

Credentialing standards for alcoholism and substance abuse counselors are in place in every state, with many licensed agencies requiring a preponderance of licensed or credentialed counselors on staff (McCrady, 2001). Even within the broader credentialed health care professions, specialty certifications in substance abuse specialties are becoming commonplace. Physicians can be credentialed by the American Society of Addictions Medicine (ASAM), and physicians specializing in psychiatry can be credentialed by the American Academy of Addiction Psychiatry. Psychologists can be credentialed through the American Psychological Association’s College of Professional Psychology, where they can receive a Certificate of Proficiency in the Treatment of Alcohol and Other Psychoactive Substance Use Disorders (McCrady, 2001).

Counselors in substance abuse practice are not as clearly defined by their educational backgrounds as in other disciplines and, depending on the state, counselors may not need a formal degree to call themselves counselors (Moyers & Hester, 1999). While all states have some type of formal credentialing, there are also national certification boards that govern certification for substance abuse counselors. The National Association of Alcohol and Drug Abuse Counselors (NAADAC) certifies three different levels of providers: (a) National Certified Addictions Counselor Level I, which requires 3 years of supervised experience; (b) National Certified Addictions Counselor Level II, which requires a baccalaureate degree, 5 years of experience, and 450 classroom hours in substance abuse content; and (c) Master Addictions Counselor, which requires a master’s degree, 2 years of postmaster’s experience, and 550 classroom hours of substance abuse content. NAADAC
certification requires counselors to pass an examination specific to each level (Moyers & Hester, 1999).

Even though it might challenge conventional wisdom, most major reviews of the literature over the past several decades have concluded that clinician experience and education do not predict effectiveness in substance abuse or general psychotherapy research (Najavits et al., 2000; Najavits & Weiss, 1994). There is abundant research noting that recovering therapists tend to have much less formal education and different types of training than their non-recovering counterparts (LoBello, 1984; McGovern & Armstrong, 1987; Shipko & Stout, 1992; Stoffelmayr et al., 1998). An argument could be made that controlling for education and training would be fruitful in ensuring that both recovering and non-recovering therapists can be examined with similar educational backgrounds, thereby limiting possible confounding effects.

The more important question may be then to understand the type rather than the amount of education and training itself. Rather than using primarily an academic degree to represent amount of education and training received, researchers might be better advised to assess training in terms of amount of time spent in studying treatment specific concepts and practices (Beutler et al., 2004). In the present study, not only was education level controlled for statistically but also the types of training were at least somewhat accounted for given the entire sample will had a nationally recognized certification in substance abuse treatment.
Process Variables that Impact Treatment Outcomes

*Working Alliance*

Strupp (1973) posits that there are three basic ingredients (conditions) in promoting therapeutic change. In the first, the therapist creates and maintains a helping relationship that is characterized by respect, interest, understanding, tact, maturity, and a firm belief in his/her ability to help. The second condition explores the function of the therapist as one who influences the client through persuasion, encouragement, interpretation, setting an example of maturity and providing a model (primarily through the first condition). The third condition requires that both preceding conditions are crucially dependent on a client who has the capacity and willingness to profit from the experience (Strupp, 1973).

Many authors have conceptualized specific frameworks and conditions that promote therapeutic change. Frank and Frank (1991) believe that all therapeutic myths and rituals have common functions. They combat demoralization by strengthening the therapeutic relationship, inspiring expectations of help, providing new learning experiences, arousing the client emotionally, enhancing a sense of mastery or self-efficacy, and affording opportunities for rehearsal and practice. Their view is that an effective working alliance is grounded in the following concepts: combating the client’s sense of alienation and strengthening the therapeutic relationship, inspiring and maintaining the clients’ expectation of help, providing new learning experiences, arousing emotions, enhancing the client’s sense of mastery or self-efficacy, and providing opportunities for practice (Frank & Frank, 1991).

Theoretical and empirical work on the construct of the working alliance has a lengthy documented history highlighted by the extensive development of specific instruments that
measure the working alliance (Tichenor & Hill, 1989). Freud (1910/1957) stated that the working alliance consists of the therapist understanding and feeling well disposed toward the client and also the encouragement of warm feelings for the therapist on the part of the client. Zetzel (1956) maintained that the alliance is formed by the client’s identification with the therapist. Zetzel believed that the alliance was critical in allowing the client to withstand the analysis of transference. Bordin, however, in a series of seminal works (1975, 1979), reconceptualized the psychoanalytic notion of the working alliance to encompass all change-inducing relationships. He clearly delineated the difference between the unconscious projections of the client (i.e., transference) and the positive joining of counselor and client against the common foe of the client’s pain and self-defeating behaviors (Horvath & Greenberg, 1989). Bordin (1979) proposed that the working alliance between the person who seeks change and the one who offers to be a change agent is one of the keys, if not the key, to the change process. Although Bordin (1979) perceived the working alliance as an integrated construct, he clearly defined three constituent components (tasks, bonds, and goals) that in combination define the quality and strength of all alliances. Some basic level of trust is necessary for any effective therapeutic encounter, but when the attention is directed toward the more protected recesses of inner experiences, deeper bonds of trust and attachment are required (Bordin, 1979).

Researchers have found that the therapeutic alliance is a significant predictor of treatment outcome across a variety of therapeutic modalities, alliance measures, and client groups (Horvath & Symonds, 1991; Luborsky et al., 1985; Saunders, 2000). In an extensive review of therapists’ attributes and in-session activities, Ackerman and Hilsenroth (2001) found that certain attributes seem to positively influence the therapeutic
alliance. They authors found that specific therapist attributes such as flexibility, experience, honesty, respect, trustworthiness, confidence, interest, alertness, friendliness, and warmth all contribute significantly to the therapeutic alliance (Ackerman & Hilsenroth, 2001). Through a meta analysis, Horvath and Symond (1991) reviewed multiple studies that explored the relationship between alliance and outcome and found that a moderate but reliable association exists between a good working alliance and positive outcome. In a study examining the association between the therapeutic bond and treatment effectiveness, Saunders (2000) found that clients who felt motivated and invested in therapy and who reported that the therapeutic environment was friendly and affirmative were likely to rate sessions as being helpful and productive. In a thorough analysis of the literature on psychotherapy and effectiveness, Wampold (2001) notes that the alliance appears to be a necessary aspect of therapy, regardless of the nature of the therapy. As Saunders (2000) points out, there is clearly more research needed to examine the complexity of the parts and purposes of the alliance in psychotherapy.

Given the existing knowledge of the relationship between the working alliance and outcome, it may be helpful to more closely examine the mechanisms of working alliance development with respect to substance abuse treatment. In one of the first studies to examine the role of therapeutic alliance in substance abuse treatment, Luborsky et al. (1985) examined 27 therapists and 110 clients and found significant correlations between a helping alliance measure and clients’ outcome. Specifically, alliance predicted clients’ drug use (.72), employment (.70), legal status (.51), and psychological functioning (.58). Similarly, in a study specifically examining substance abuse clients, Barber et al. (1999) found that 252 cocaine dependent outpatients’ reports of the alliance predicted drug
outcomes after 1 month of treatment but not at a 6 month follow up assessment. However, in a similar study of 308 cocaine-dependent clients, Barber et al. (2001) found that while high levels of therapeutic alliance were observed consistently, these findings of therapeutic alliance did not predict drug outcomes in the client sample.

In Project MATCH, DiClemente et al. (2003) found that measures of working alliance, whether provided by the client or by the therapist in the outpatient sample of the trial, were significant predictors of treatment participation and of the frequency and intensity of drinking, both during the treatment period and during the post-treatment follow up. They also found that client ratings and therapist ratings were not highly correlated, and that client ratings were stronger predictors of treatment participation and outcome than that of therapist ratings (DiClemente et al., 2003).

It would appear that therapists’ ability to establish an effective working alliance has strong implications for the outcome of therapy in substance abuse treatment. The central goal becomes then, methodologically, to control for potentially confounding therapist characteristics such as training, education, experience, and theoretical orientation so differences due to these variables become more discernable (Najavits & Weiss, 1994). However, what these studies often have difficulty controlling for effectively is the complexity and interactions of moderating and mediating variables, such as therapist emotional reactions, well-being, expectancies, and vulnerabilities (Horvath & Bedi, 2002). The present study seeks to address these methodological concerns.

*Empathy*

Empathy is a construct that seems to transcend theoretical belief systems. From humanistic to psychoanalytic to cognitive behavioral theorists, empathy is seen as a
necessary condition in promoting therapeutic change (Miller & Baca, 1983). Some view empathy as a primarily affective phenomenon, while others view empathy as a cognitive process. As Duan and Hill (1996) point out, empathy involves intellectually or cognitively taking the role or perspective of another. Alternately, “affective” empathy denotes responding with the same emotion to another person’s emotion or affect. Truax and Carkhuff (1967) make the distinction with respect to identifying and measuring empathy that it is not necessary to share the client’s feelings. Rather, empathy is an appreciation and a sensitive awareness of the client’s feelings. Their definition of accurate empathy is worth noting:

Accurate empathy involves more than just the ability of the therapist to sense the client’s “private world” as if it were his (or her) own. It also involves more than just his (or her) ability to know what the client means. Accurate empathy involves both the therapist’s sensitivity to current feelings and his (or her) verbal facility to communicate this understanding in a language attuned to the client’s current feelings. (Truax & Carkhuff, 1967, p. 46)

Regardless of the type of empathy (cognitive or affective), it is often considered to be a potent variable in the therapeutic relationship and has often been thought of as providing a “corrective emotional experience” (Bohart et al., 2002).

There are multiple instruments that seek to measure empathy. These measures often tap the cognitive or intellectual construct of empathy. Both direct observational assessment of empathy (Miller et al., 1991; Truax & Carkuff, 1967) and client ratings of empathy (Barrett-Lennard, 1962) have been used in psychotherapy research. In substance abuse treatment, ratings of empathy consistently correlates with outcome (Miller & Baca, 1983;
Miller et al., 1980; Miller et al., 1993; Miller et al., 2003). Miller et al. (1980) found that accurate empathy accounted for 67% of the variance in success, as defined by client drinking behavior. In the same sample, Miller and Baca (1983) found that this trend continued with percentages of cases achieving successful outcomes related to therapist empathy at a 12 month ($r = .71$) and 24 month ($r = .51$) follow up, although the strength of relationship declined over time. Additionally Valle (1981) and Saarnio (2002) reported that client outcomes among alcoholics were predicted based on therapists’ interpersonal functioning, including empathy.

With respect to recovery status and empathy, Lawson (1982) found that clients of counselors who themselves had been treated for alcoholism rated their counselors as more empathic. This was evidenced by client report on the Barrett-Lennard Relationship Inventory (BLRI, Barrett-Lennard, 1962). Lawson found that clients of recovered alcoholics reported not only higher total BLRI scores, but also higher levels of regard and unconditionality on the BLRI subscales. Kirk et al. (1986), however, set out to find differences between recovering and non-recovering counselors’ ability to empathize with their clients. The authors hypothesized that recovering counselors, given their similar backgrounds and experiences to clients, would be able to convey commonality, support, understanding, and an empathic posture. The authors found no difference between the two groups with respect to BLRI scores.

Both working alliance and empathy are process variable that seem to be strong predictors of outcome in substance abuse treatment. The therapists’ role in providing these conditions is central to the current study. All too often in substance abuse counseling, recovery status is examined as a fixed demographic variable, and is often found to be
unrelated to specific process variables and outcomes. What may be more helpful is to examine therapists’ variables that impact the treatment process, while examining potential differences between recovering and non-recovering therapists’ therapeutic effectiveness.

Counselor Credibility

The client’s perceptions of the counselor’s behavior determine to a large extent the effectiveness of counseling (Barak & LaCrosse, 1975). Some of these perceptions might be related to the counselor’s expertness, credibility, trustworthiness, and attractiveness. Strong’s (1968) “interpersonal influence” theory posits that when counselors are perceived by clients as expert, attractive, and trustworthy, they will be more influential than counselors who are not perceived in this way.

While there have been many studies testing Strong’s theory, the research is limited with respect to client outcomes in a clinical setting. One such study (LaCrosse, 1980) examined the predictive validity of social influence dimensions, and this study just happened to be with a substance abuse population. Thirty-six clients and four counselors participated in the study. Client perceptions of counselor behavior were measured by the Counselor Rating Form, developed by Barak and LaCrosse (1975). Outcome was measured via clients’ specific, observable, and quantifiable treatment goals. The study found that greater perceived counselor social influence at intake was significantly related to better counseling outcomes. Specifically, results suggested that initial perceptions of expertness, attractiveness, and trustworthiness strongly predicted outcomes, with expertness accounting for the majority of variance in outcomes (LaCrosse, 1980).
Session Quality

Session quality is another process variable that impacts treatment, and may be prone to variations in therapists’ effectiveness. As Stiles et al. (2002) point out, psychotherapy sessions are often judged in at least two distinct ways. Psychotherapy sessions may be judged as either deep (powerful, effective) versus shallow (weak, worthless), or smooth (relaxed, comfortable) versus rough (tense, distressing). Saunders (1999) found that clients’ in-session affective experiences and emotional dimensions of pleasure versus distress played a fundamental role in the therapy process. Saunders used factor analysis to reveal six stable factors of client’s affective experiences in therapy (Client Distressed, Client Remoralized, Reciprocal Intimacy, Therapist Confident Involvement, Client Inhibited, and Therapist Distracted). Clients’ affective experiences were found to correlate highly with clients’ report of session quality and judge’s ratings of overall treatment effectiveness (Saunders, 1999).

In substance abuse treatment, in-session factors may provide a glimpse into the style and behavior characteristics of substance abuse counselors. There often is a complex array of client characteristics associated with substance abuse treatment such as denial, defensiveness, masking or minimizing symptoms, and variable motivation levels. This can often lead to a directive, authoritarian, and confrontational therapeutic style (Miller et al., 1993). Such counselor styles may not always lead to beneficial outcomes. Milmore et al. (1967) found that feelings and attitudes conveyed in physicians’ speech were related to their success in referring alcoholic clients for treatment. Doctors whose tone was rated by judges as more angry and irritated were found to be less effective (referring clients to necessary services) than doctors rated as affable. The authors highlight the importance of
these findings suggesting that alcoholic clients may be especially sensitized to perceived rejection.

Miller et al. (1993) found similar results when investigating 42 problem drinkers who were randomly assigned to three distinct groups, which included a directive feedback condition, a client-centered condition, and a control condition. In the directive feedback condition, interviewers were instructed to confront client resistances, give direct advice, and disagree with clients’ minimizations of problems. In the client-centered condition, interviewers were instructed to utilize empathy skills with no attempts to force a subject to “face up to reality.” The authors found that confrontation behavior on the part of the therapist proved to be predictive of poorer drinking outcomes at 12 months after initial session. Miller et al. (1993) point out that confrontation and empathy may not be inherently incompatible. The authors suggest that confrontation does not have to translate into going “head to head” but may be more appropriately expressed as “to bring face to face.”

How This Study Proposed to Address Some of These Important Questions

As the current review highlights, therapists in substance abuse counseling provide a fertile research environment to examine the impact of the therapists’ characteristics on the therapy process. The current study examined this topic with the hope of providing some unique perspectives that have not previously been explored. Specifically, this study investigated specific therapist variables having potential impact on the process of therapy, namely therapist well-being and therapist emotional reactions towards clients, while controlling for therapists’ education and training levels. Therapist characteristics were expected to relate to variables that constitute effective process such as client ratings of the
working alliance, counselor empathy, session quality, counselor credibility, and therapists’ ratings of prognostic expectancies.

As part of this research, I hoped to explore how the therapeutic process differed for substance abuse therapists who are and who are not in recovery. To accomplish this task, I examined the interaction between therapist well-being and recovery status, and its relationship with therapy process variables. I hypothesized that recovering therapists with greater well-being would be able to capitalize on their recovery status attributes, thus engaging in more effective process compared to recovering therapists who are more psychologically impaired. I expected that recovering therapists with greater well-being would engage in more effective process compared to their non-recovering counterparts. If therapists’ variations in effectiveness were discovered, it may help to explain which therapeutic paths lead to different rates of effectiveness.

Research Hypotheses

1. Therapists reporting a higher degree of well-being will be viewed by their clients as more effective.

2. Therapists reporting stronger negative emotional reactions towards clients will be viewed by their clients as less effective.

3. Therapists’ report of well-being and positive emotional reactions towards clients will be significantly positively related to therapists’ prognostic expectancies for clients.

4. Therapists’ well-being will interact with recovery status to predict client perceptions of effectiveness, such that recovering therapists with greater well-being
will have better effectiveness than recovering therapists with poorer well-being, and better effectiveness than non-recovering therapists, regardless of their well-being.
Chapter 3: Method

Participants

The sample for this study included both counselors and clients. Five hundred counselors were randomly selected from a sample of nationally board-certified substance abuse counselors. The sample was drawn from NAADAC: The Association for Addiction Professionals (Formerly the National Association of Alcoholism and Drug Abuse Counselors). According to their website, NAADAC is the largest professional membership organization serving counselors who specialize in addiction treatment. There are currently 12,000 members in NAADAC representing 47 states. The present study drew from the National Certified Addiction Counselor II pool, which requires each counselor to hold at least a bachelor’s degree and current state certification in the counselor’s respective state. Additionally, eligibility required that each participant holding the National Certified Addiction Counselor II had completed five years of full time experience as a substance abuse counselor and at least 450 contact hours in education and training, as well as achieving passing score on the national examination for Level II for NAADAC.

A total of 51 counselors participated in the study, approximately half ($n = 25$) of whom were women. Counselor participants’ ages ranged from 35-75 years, with an average age of 55. The majority of counselor participants were European American ($n = 46$), with 2 African Americans, 1 Hispanic, 1 Native American, and 1 other. Counselor participants had an average of 22 years of counseling experience, ranging from 2 to 33 years. All counselor participants had at least a bachelor’s degree, with most having a graduate degree. Highest degree received included: bachelor’s ($n = 7$), master’s ($n = 35$), and doctorate ($n = 8$). Many theoretical orientations were represented including cognitive
behavioral \( (n = 14) \), 12-step \( (n = 10) \), eclectic \( (n = 6) \), systems \( (n = 5) \), humanistic \( (n = 1) \), psychodynamic \( (n = 1) \), and other \( (n = 7) \). The majority of counselor participants reported that they worked in a private practice setting \( (n = 24) \). The remainder of counselors were employed in an outpatient clinic setting \( (n = 14) \) or inpatient setting \( (n = 9) \), with 4 reporting “other.”

The majority of counselor participants identified as being in recovery \( (n = 34) \). These participants reported having an average of 25 years of recovery, with a range of 13-37 years of recovery. Counselor demographics in the current sample were compared to a national sample (NAADAC; 2003) with respect to gender, age, race/ethnicity, education, and recovery status (see Table 6).

Of the 40 clients, 16 were male and 24 were female. The mean age of clients was 39 with a range of 19-62 years. The majority of clients were European American \( (n = 28) \), with 5 African Americans, 1 Asian American, 3 Hispanic, and 1 Native American. Clients indicated how many sessions they had been working with their respective counselors. Their responses ranged from 3 sessions to 300 sessions, with an average of 47 sessions.

**Independent Variables**

*Demographic variables.* A questionnaire assessed all participants’ age, gender, racial/ethnic background, and for counselors, education level, years of experience, work setting, theoretical orientation, and recovery status (including length of time in recovery, see Appendix E & L).

*Therapist well-being.* Therapist well-being was measured with the Behavioral Health Questionnaire-20 (BHQ-20; Kopta & Lowry, 2002; see Appendix G). The BHQ-20 is a 20-item self-report measure that assesses global mental health. Counselor participants are
asked to rate items on a Likert-type scale ranging from 0 (extreme distress/poor functioning) to 4 (no distress/excellent functioning). Higher scores reflect better overall mental health. Subscales include Well-Being, Psychological Symptoms, and Life Functioning. The Well-Being scale evaluates emotional distress, motivation/energy, and life satisfaction. The Symptoms scale includes items that assess depression, anxiety, drug/alcohol abuse, and risk (harm to oneself and to others). Life Functioning areas are work/school, intimate relationships, nonfamily relationships, and life enjoyment (Kopta & Lowry, 2002). Only the total score was used in the present study.

Kopta and Lowry (2002) assessed internal consistency for four different samples (community adults, college students, college counseling clients, and psychotherapy outpatients) and found estimates for coefficient alpha to be between .89 and .90 for Global Mental Health. Concurrent validity for the overall Global Mental Health score on the BHQ-20 has been demonstrated via correlations with similar measures of psychological health including overall scores on the BASIS-32 (.83), COMPASS (.76), OQ-45 (.81), and SCL-90-R (.85). In the current study, coefficient alpha for the total BHQ was .91.

Counselor attitudes and reactions. Counselor attitudes and reactions towards clients were measured by the Ratings of Emotional Attitudes to Clients by Treaters (REACT; Najavits et al., 1995; see Appendix H). The REACT is a 40-item self-report measure in which therapists rate their emotional responses to clients on a 1 (Never) to 5 (Very Often) scale. The measure contains four factors. Three factors are considered negative: Therapist Conflict with Self, Therapist Conflict with Client, and Therapist Focus on Meeting Own Needs. Higher scores indicate stronger negative reactions. Some examples of items include “Doubting my competence in relation to the client,” “Cautious or uneasy
confronting or setting limits with the client,” and “Disappointed with client or the
treatment.” One factor is considered positive: Positive Connection to Client. An example
item includes, “Enjoyment with the client.” Internal consistency of the REACT has been
found to be high with Cronbach’s alphas ranging from .80 to .82 for overall scores
(Najavits et al., 1995). The REACT also was found to be correlated with measures of
therapeutic alliance, including both therapist and client ratings. Specifically, correlations
between the REACT and therapist versions of therapeutic alliance ranged from .53 to .73.
Correlations with client versions ranged from .21 to .33 (Najavits et al., 1995). In the
current study, coefficient alpha for the total REACT score was .86.

**Dependent Variables**

**Session depth.** Session depth was measured by the Session Evaluation Questionnaire
(SEQ; Stiles, 1980; see Appendix L). The SEQ is a widely used semantic differential
instrument, which measures the evaluative or connotative meanings of session impact
through a set of bipolar adjectives. The SEQ is typically scored for two scales: Depth and
Smoothness (Elliot & Wexler, 1994). Each item is scored from 1 to 7, reversed as
appropriate, with higher scores indicating greater Depth and Smoothness. For the current
study, only the Depth scale consisting of 5 items was used. Sample items include
“Deep/Shallow,” and “Valuable/Worthless.” Internal consistency, measured by coefficient
alpha, has been high across a wide variety of conditions and settings (Stiles, Gordon, &
Lani, 2002). In the current study, coefficient alpha for total SEQ score was .93.

**Empathy.** Empathy was measured by the Barrett-Lennard Relationship Inventory
(BLRI, Barrett-Lennard, 1962, see Appendix J). The instrument is a subjective measure of
the extent to which clients feel understood by their counselors (Duan & Hill, 1996). The
BLRI is believed to be the most commonly used measure of counselor empathy in counseling and psychotherapy (Greenberg & Watson, 1998; Hill, Nutt, & Jackson, 1994). The current study used the BLRI Empathic Understanding subscale. This subscale has been used independently to measure empathic understanding in prior research with effective results (Greenberg & Watson, 1998; Maurer & Tindall, 1983). The BLRI Empathic Understanding subscale consists of 10 items rated on a 6-point Likert-type scale from +3 to -3 (+3 = Yes, I strongly feel that is true; -3 = No, I strongly feel that is not true). Sample items of the Empathic Understanding subscale include “My counselor usually senses or realizes what I am feeling,” and “My counselor doesn’t listen and pick up on what I think and feel.” Satisfactory split-half reliability for the Empathic Understanding subscale was .86 (Ponteroto & Furlong, 1985). In the current study, the coefficient alpha for the total BLRI score was .80.

*Working alliance.* Working alliance was measured by the client version of the Working Alliance Inventory (WAI-C, Horvath & Greenberg, 1989, see Appendix K). The WAI-C is based on Bordin’s (1975, 1979) theory that the working alliance is part of an integrated therapeutic relationship consisting of tasks, goals, and bonds between therapist and client. The WAI-C contains three subscales: Tasks, Goals, and Bond, each with 12 items rated on a 7-point Likert-type scale (1 = Never, 7 = Always). The Tasks subscale indicates how responsive the therapist is to the client’s focus and needs. The Goals subscale refers to the extent to which goals are seen as important, mutual, and capable of being accomplished. The Bond subscale refers to the degree of mutual liking, trust, and attachment (Tichenor & Hill, 1989). The measure is scored so that higher scores indicate a higher experience or perception of the particular subscale construct. The client version of the WAI has been
shown to have strong internal consistency across multiple studies with estimated alphas of .93 (Horvath & Greenberg, 1989), .96 (Tichenor & Hill, 1989), and .94 (Cecero et al., 2001). There has also been evidence supporting the convergent, discriminant, and predictive validity of the WAI subscales (Horvath & Greenberg, 1989). The present study used the 12 item short form of the WAI-C, which has been shown to have similar factor structure to that of the original 36 item form (Tracey & Kokotovic, 1989). Sample items include, “My counselor and I agree about the things I will need to do in therapy to help improve my situation,” “My counselor and I are working towards mutually agreed upon goals,” and “My counselor and I trust one another.” In the current study, the coefficient alpha for the total WAI score was .88.

**Expectancy of outcome.** Counselors’ prognostic expectancies was measured by the Therapist Expectancy Inventory (TEI, Bernstein et al., 1983, see Appendix I). The TEI includes 65 total items designed to represent three primary categories of therapist expectancies. These include diagnostic expectancies, prognostic expectations, and process expectations. A Likert scale from 1 (Not at all expect) to 7 (Greatly expect) is used. For the present study, only those 9 items on the Expectancy of Outcome factor were used. Higher scores reflect the therapist’s greater prognostic and outcome expectancies. The therapist predicts post-intervention change in the client’s degree of autonomy, self-understanding, and social competence (Bernstein et al., 1983). Sample items include “After intervention, this client will have a greater self-knowledge,” and “After intervention, this client will make more effective decisions.” Item-total correlations range from .59 to .73, and split-half alpha coefficients for Expectancy of Outcome subscale was found to be
.84 (Bernstein et al., 1983). In the current study, the coefficient alpha for total TEI score was .92.

Counselor credibility. Counselor credibility will be measured with the Counselor Rating Form (CRF) developed by Barak and LaCross (1975, see Appendix M). Originally, the CRF consisted of 36 bipolar items, 12 for each of three attribute dimensions: Attractiveness, Expertness, and Trustworthiness. Each item consisted of an adjective and its antonym (e.g., friendly-unfriendly) at the extremes of a seven point bipolar scale. Reliability coefficients using the Spearman-Brown formula were calculated for each of the scales, and are as follows: .87 for Expertness, .85 for Attractiveness, and .91 for Trustworthiness (Barak & LaCross, 1975). LaCross (1980) found support for the predictive validity of the CRF as client ratings on the three dimensions were significantly correlated with treatment outcome ($r = .37$ to $.56$). The CRF Shortened version (CRF-S, Corrigan & Schmidt, 1983) reduced the number of items to 12 while maintaining the original subscales of Attractiveness, Expertness, and Trustworthiness. The CRF-S is a 12-item instrument on which respondents rate their perceptions of their counselor by using a 7-point scale with anchors of 1 (not very) and 7 (very). While summing the items yielded three distinct four-item subscale scores of Attractiveness, Expertness, and Trustworthiness, there is evidence that the CRF-S total score yields a global Positive-Evaluation factor that reflects the extent to which the counselor is viewed in a good light (Tracey & Kokotivic, 1988). Internal consistency estimates (interitem reliability) for the CRF-S were found to have alphas of .91 (Attractiveness), .85 (Expertness), and .91 (Trustworthiness, Corrigan & Schmidt, 1983). In the current study, the coefficient alpha for total CRF score was .93.
Procedure

Once a random sample of 500 counselors was acquired from NAADAC, each participant received a pre-notification letter (see Appendix A) which provided a brief overview of the study, requirements for participation, and a notification that the participant will be receiving a packet in the next week or so. In the packet, counselors received a cover letter (see Appendix B), counselor measures, a postage paid return envelope, and client packet. All counselor cover letters were personally addressed and hand signed. Instruments were coded to track non-respondents. Counselors were offered two incentives for participating in the present study. The first was that counselors were informed that their completed packets (with client survey) would result in one dollar being donated to the Hazelden Foundation, a well known private alcohol and drug treatment facility. Additionally, counselors were informed that completed packets would each be randomly entered in ten separate drawings for $25 gift certificates to Barnes and Noble. Participating counselors were also offered the chance to receive summary findings from the study.

Each counselor selected the next adult client with whom they were working on substance abuse issues in individual counseling and they were instructed to give the provided “client packet” to that client. Participating counselors were then asked to complete a survey containing several demographic items (the BHQ-20, the REACT, and the TEI) in randomized order. The counselors were reminded that the REACT and the TEI should be completed with respect to the client receiving the packet.

Once receiving the packet from their counselor, the client found a letter outlining the study (see Appendix F), a postage paid return envelope, a brief demographic form (see
Appendix L), and several surveys inside the packet including the WAI-C, the BLRI, the CRF, and the SEQ in random order. The clients were informed that questionnaires should take no longer than 10-20 minutes to complete.

When there was no initial response from counselors within 3 weeks, a reminder letter (see Appendix C) was sent. Approximately 2 weeks after the reminder letter was sent, a follow up packet (with the same materials used in initial mailing) was mailed. Once a counselor completed the instruments, mailed them, and had given the additional instruments to their identified clients, they had completed their participation in the survey. Once each client completed their instruments and returned them by mail, they had completed their participation in the survey.

Of the 500 counselors surveyed, 193 mailings were sent back due to incorrect addresses, 14 counselors had retired, and 3 were deceased. Of the remaining 290 eligible participants, 51 returned completed packets, for an 18% response rate. Of the 51 counselors, 40 (78%) of their clients returned completed packets.
Chapter 4: Results

Preliminary Analyses

Means, standard deviations, and ranges were assessed for all primary variables (see Table 1). Bivariate correlations were computed for each variable (see Table 2). Among dependent variables, correlations ranged from .35 (BLRI and TEI) to .73 (BLRI and SEQ). In terms of the relationships between independent and dependent variables, BHQ scores did not correlate significantly with any other variable in the study. REACT scores however, correlated significantly at the .05 level with scores on the WAI ($r = -.48$), BLRI ($r = -.41$), and TEI ($r = -.34$). Using SPSS, collinearity tolerance values for dependent variables ranged from .37 (BLRI and SEQ) to .40 (WAI), values which fall within acceptable limits (Tabachnick & Fidel, 2001).

Primary Analysis

The first hypothesis was that therapists reporting a higher degree of well-being will be viewed by their clients as more effective. To test this hypothesis, a multivariate multiple regression analysis was conducted. BHQ scores were the independent variable and WAI, BLRI, CRF, and SEQ scores were the dependent variables. The results did not support the hypothesis ($R = .23$; $F (4, 31) = .41$; $p > .05$).

The second hypothesis was that therapists reporting stronger negative reactions towards clients will be viewed by their clients as less effective. To test this hypothesis, a multivariate multiple regression analysis was conducted. REACT scores were the independent variable and WAI, BLRI, CRF, and SEQ scores were the dependent variables. The results supported this hypothesis ($R = .61$; $F (4, 34) = 5.10$; $p < .01$); therapists with stronger negative reactions towards clients were seen as less effective by these clients.
Specifically, clients’ WAI ($R = .51$; $F (1, 37) = 13.18; p < .01$) and BLRI ($R = .45$; $F (1, 37) = 9.20; p < .01$) scores were significantly related to counselors’ REACT scores.

The third hypothesis was that therapists’ well-being and emotional reactions towards clients will be significantly related to therapists’ prognostic expectancies for clients. To test this hypothesis, a simultaneous multiple regression test was conducted. BHQ and REACT scores were the independent variables and TEI scores were the dependent variable. The results did not support this hypothesis ($R = .34; F (2, 43) = 2.84; p > .05$).

The fourth hypothesis was that there will be an interaction effect between therapist recovery status and well-being on effectiveness, such that recovering therapists with greater well-being will be perceived as more effective than non-recovering therapists. A multivariate multiple regression was conducted. Recovery status, BHQ scores, and an interaction variable (Recovery status x BHQ scores) were the independent variables. WAI, BLRI, CRF, and SEQ scores were the dependent variables. The results did not support this hypothesis ($R = .47; F (4, 29) = 2.13; p > .05$).

*Additional Analyses*

Given the significant findings with respect to the second hypothesis where therapists reporting stronger negative reactions (REACT) towards clients were viewed by their clients as less effective, further analyses were conducted to examine the subscales of the REACT. The REACT has four subscales that delineate the nature of therapists’ emotional reactions. Subscale 1 is the therapist In Conflict with Self and is composed of 11 items. Subscale 2 is the therapist Focusing on Own Needs and is composed of 7 items. Subscale 3 is the therapist having Positive Connections with client and consists of 6 items, and subscale 4 is the therapist In Conflict with Client, comprising 4 items (Najavits et al., 1995).
To determine the relationship between each subscale and effectiveness, four multivariate regression analyses were conducted with each subscale as the independent variable and WAI, BLRI, SEQ, and CRF scores as dependent variables. For the subscale In Conflict with Self, there was a significant finding in that therapists in conflict with self were viewed as less effective by clients ($R = .58; F(4, 34) = 4.30; p < .01$). Among the dependent variables, only WAI scores were significantly related to In Conflict with Self scores ($R = .49; F(1, 39) = 11.90; p = .001$). For Focusing on Own Needs, there were also significant findings ($R = .52; F(4, 34) = 3.16; p < .05$), such that therapists focusing on their own needs were seen as less effective by their clients. Further review of the dependent variables revealed that no single dependent variable was significantly related to Focusing on Own Needs. For Positive Connections, there were significant findings ($R = .66; F(4, 34) = 6.68; p < .001$), such that therapists reporting a more positive connection with clients were viewed as more effective by their clients. All four dependent variables reached significance including WAI ($R = .46; F(1, 39) = 9.72; p < .01$), BLRI ($R = .66; F(1, 39) = 28.25; p < .001$), CRF ($R = .46; F(1, 39) = 9.87; p < .01$), and SEQ ($R = .44; F(1, 39) = 8.81; p < .01$). The subscale In Conflict with Client did not predict client ratings of therapist effectiveness ($R = .43; F(4, 34) = 1.93; p > .05$).

As previously noted, the fourth hypothesis in the study examined an interaction between therapist recovery status, well-being, and effectiveness, to determine if recovering therapists with greater well-being would be perceived as more effective than non-recovering therapists. While the hypothesis was not supported, there may be alternative interaction effects that could explain the function of therapist recovery status. Given the findings with respect to the REACT scores, further analyses were conducted to test whether
there was an interaction between therapist recovery status, emotional reactions, and effectiveness. In particular, I examined whether recovering therapists with stronger negative reactions towards their clients were viewed as less effective by clients. To test this, a multivariate multiple regression was conducted. Recovery status, REACT scores, and an interaction variable (Recovery status x REACT scores) were the independent variables. WAI, BLRI, CRF, and SEQ scores were the dependent variables. The results were not statistically significant ($R = .35; F (2, 32) = 1.20; p > .05$).

There has been extensive debate about the relative effectiveness of therapists who are and who are not in recovery, even though most data suggest that outcomes tend to be equivalent for the two groups (Culbreth, 2000; Najavits & Weiss, 1994; Project MATCH, 1998). The question remains whether the two groups might rely on different processes for attaining their comparable effectiveness. That is, do they differ on empathy, working alliance, credibility, or session depth? To examine this question, a MANOVA was conducted with recovery status as the independent variable and BLRI, WAI, CRF, and SEQ scores as dependent variables. The results indicated no significant differences between the two groups ($F (4, 34) = .06, p = .99$). Means and standard deviations on dependent variables for both groups are presented in Table 3.

While most data suggest that clinician education does not predict effectiveness in substance abuse treatment (Najavits et al., 2000; Najavits & Weiss, 1994), there are consistent findings indicating that recovering and non-recovering therapists differ with respect to education levels (LoBello, 1984; McGovern & Armstrong, 1987; Shipko & Stout, 1992; Stoffelmayr et al., 1998). The current study attempted to minimize variability in therapist education level by sampling certified therapists with at least a bachelor’s
degree. There was, however, some variability with respect to the amount of post-secondary education therapists had. To see if variability in education may have impacted client effectiveness ratings, a MANOVA was conducted with education level (Bachelor’s, Masters, Doctorate) as the independent variable, and WAI, BLRI, CRF, and SEQ scores as dependent variables. The results did not reveal any significant differences with respect to education level ($F(4, 34) = .27, p = .89$). Means and standard deviations for all education groups on dependent variables are presented in Table 4. Additionally, a Chi-Square test was performed to see if there were significant differences for recovering and non-recovering therapists in education levels. The results were not significant ($X^2 = 5.4, df = 4, p = .25$). In fact, recovering therapists held a similar percentage of post secondary degrees when compared with non recovering therapists (see Table 5). To see if there may be a relationship between recovery status, education levels, and effectiveness, a MANCOVA was conducted. Recovery status was the independent variable, education level was the covariate, and WAI, BLRI, CRF, and SEQ scores were dependent variables. The results were not statistically significant ($F(4, 33) = .16, p = .96$). Additional counselor demographic variables (e.g., gender, age, ethnicity, theoretical orientation, and work setting) were examined to see if they predicted effectiveness. Results from these analyses were not significant.
### Table 1

Means, Standard Deviations, and Ranges for Independent/Dependent Variables

<table>
<thead>
<tr>
<th>Measure</th>
<th>M</th>
<th>SD</th>
<th>Range</th>
<th>Possible Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>REACT</td>
<td>1.86</td>
<td>.30</td>
<td>1.26 to 2.55</td>
<td>1 to 5</td>
</tr>
<tr>
<td>BHQ</td>
<td>3.44</td>
<td>.44</td>
<td>1.65 to 4.00</td>
<td>0 to 4</td>
</tr>
<tr>
<td>WAI</td>
<td>5.93</td>
<td>.76</td>
<td>3.92 to 7.00</td>
<td>1 to 7</td>
</tr>
<tr>
<td>BLRI</td>
<td>2.22</td>
<td>.60</td>
<td>0.60 to 3.00</td>
<td>-3 to 3</td>
</tr>
<tr>
<td>SEQ</td>
<td>5.93</td>
<td>.99</td>
<td>3.20 to 7.00</td>
<td>1 to 7</td>
</tr>
<tr>
<td>CRF</td>
<td>6.53</td>
<td>.62</td>
<td>4.42 to 7.00</td>
<td>1 to 7</td>
</tr>
<tr>
<td>TEI</td>
<td>5.44</td>
<td>.84</td>
<td>3.56 to 7.00</td>
<td>1 to 7</td>
</tr>
</tbody>
</table>

*Note:* REACT = Ratings of Emotional Attitudes to Clients by Therapists. BHQ = Behavioral Health Questionnaire. WAI = Working Alliance Inventory. BLRI = Barrett-Lennard Relationship Inventory. SEQ = Session Evaluation Questionnaire. CRF = Counselor Rating Form. TEI = Therapist Expectancy Inventory.

### Table 2

Intercorrelations Among Primary Variables

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. REACT</td>
<td>-</td>
<td>-.08</td>
<td>-.48**</td>
<td>-.41*</td>
<td>-.34*</td>
<td>-.19</td>
<td>-.20</td>
</tr>
<tr>
<td>2. BHQ</td>
<td></td>
<td>-.05</td>
<td>.01</td>
<td>.05</td>
<td>-.11</td>
<td>-.03</td>
<td></td>
</tr>
<tr>
<td>3. WAI</td>
<td></td>
<td></td>
<td>.68**</td>
<td>.72**</td>
<td>.70**</td>
<td>.68**</td>
<td></td>
</tr>
<tr>
<td>4. BLRI</td>
<td></td>
<td></td>
<td></td>
<td>.35*</td>
<td>.67**</td>
<td>.73**</td>
<td></td>
</tr>
<tr>
<td>5. TEI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.41*</td>
<td>.41*</td>
<td></td>
</tr>
<tr>
<td>6. CRF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.71**</td>
<td></td>
</tr>
<tr>
<td>7. SEQ</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-</td>
</tr>
</tbody>
</table>

*Note:* REACT = Ratings of Emotional Attitudes to Clients by Therapists. BHQ = Behavioral Health Questionnaire. WAI = Working Alliance Inventory. BLRI = Barrett-Lennard Relationship Inventory. TEI = Therapist Expectancy Inventory. CRF = Counselor Rating Form. SEQ = Session Evaluation Questionnaire.  
*p ≤ .05, two-tailed.  **p ≤ .01, two-tailed.*
### Table 3

Recovery Status, Means, and Standard Deviations of Dependent Variables

<table>
<thead>
<tr>
<th>Measure/Recovery Status</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WAI</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recovery</td>
<td>5.92a</td>
<td>.75a</td>
</tr>
<tr>
<td>Non recovery</td>
<td>5.90b</td>
<td>.88b</td>
</tr>
<tr>
<td><strong>BLRI</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recovery</td>
<td>2.24a</td>
<td>.62a</td>
</tr>
<tr>
<td>Non recovery</td>
<td>2.16b</td>
<td>.53b</td>
</tr>
<tr>
<td><strong>CRF</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recovery</td>
<td>6.52a</td>
<td>.62a</td>
</tr>
<tr>
<td>Non recovery</td>
<td>6.51b</td>
<td>.65b</td>
</tr>
<tr>
<td><strong>SEQ</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recovery</td>
<td>5.93a</td>
<td>1.20a</td>
</tr>
<tr>
<td>Non recovery</td>
<td>5.90b</td>
<td>.77b</td>
</tr>
</tbody>
</table>

*Note: WAI = Working Alliance Inventory. BLRI = Barrett-Lennard Relationship Inventory. CRF = Counselor Rating Form. SEQ = Session Evaluation Questionnaire.  
  \(^a\) n = 33.  \(^b\) n = 17.*
Table 4

Education Levels and Means and Standard Deviations of Dependent Variables

<table>
<thead>
<tr>
<th>Measure/Education Level</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>WAI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bachelor’s</td>
<td>6.03</td>
<td>.69</td>
</tr>
<tr>
<td>Master’s</td>
<td>5.83</td>
<td>.84</td>
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<tr>
<td>Doctorate</td>
<td>6.25</td>
<td>.78</td>
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<tr>
<td>BLRI</td>
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<td></td>
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<tr>
<td>Bachelor’s</td>
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<tr>
<td>Master’s</td>
<td>2.19</td>
<td>.66</td>
</tr>
<tr>
<td>Doctorate</td>
<td>2.47</td>
<td>.25</td>
</tr>
<tr>
<td>CRF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bachelor’s</td>
<td>6.63</td>
<td>.38</td>
</tr>
<tr>
<td>Master’s</td>
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<td>.59</td>
</tr>
<tr>
<td>Doctorate</td>
<td>6.85</td>
<td>.16</td>
</tr>
<tr>
<td>SEQ</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bachelor’s</td>
<td>6.03</td>
<td>.82</td>
</tr>
<tr>
<td>Master’s</td>
<td>5.82</td>
<td>1.10</td>
</tr>
<tr>
<td>Doctorate</td>
<td>6.40</td>
<td>.55</td>
</tr>
</tbody>
</table>

Note: WAI = Working Alliance Inventory. BLRI = Barrett-Lennard Relationship Inventory. CRF = Counselor Rating Form. SEQ = Session Evaluation Questionnaire.

Table 5

Education Levels for Recovering and Non Recovering Therapists*

<table>
<thead>
<tr>
<th>Education level</th>
<th>Recovering</th>
<th>Non Recovering</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bachelor’s</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Masters</td>
<td>21</td>
<td>6</td>
</tr>
<tr>
<td>Doctorate</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>11</td>
</tr>
</tbody>
</table>

Note: *Data reflect only those therapists with clients participating in study (N = 40)
Table 6

Comparison of Therapist Characteristics Between Current Sample and National Sample

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Current Sample (%)</th>
<th>National Sample (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>50</td>
<td>44</td>
</tr>
<tr>
<td>Female</td>
<td>50</td>
<td>57</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25-34</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>35-44</td>
<td>8</td>
<td>21</td>
</tr>
<tr>
<td>45-54</td>
<td>39</td>
<td>40</td>
</tr>
<tr>
<td>55-65</td>
<td>39</td>
<td>26</td>
</tr>
<tr>
<td>65+</td>
<td>14</td>
<td>6</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
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<td></td>
</tr>
<tr>
<td>African American</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
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<td>3</td>
</tr>
<tr>
<td>White</td>
<td>90</td>
<td>87</td>
</tr>
<tr>
<td>Other</td>
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<td>5</td>
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<tr>
<td>Education</td>
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<tr>
<td>Bachelor’s</td>
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<tr>
<td>Master’s</td>
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<td>Doctorate</td>
<td>16</td>
<td>7</td>
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<tr>
<td>Recovery Status</td>
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<tr>
<td>Recovery</td>
<td>67</td>
<td>54</td>
</tr>
<tr>
<td>Non-recovery</td>
<td>33</td>
<td>46</td>
</tr>
</tbody>
</table>
Chapter 5: Discussion

Main Effects

The first hypothesis in the current study predicted that therapists reporting a higher degree of well-being would be viewed by their clients as more effective. Multivariate multiple regression analyses failed to support this hypothesis. There was no relationship between therapists’ reports of well-being and clients’ perception of therapists’ effectiveness. Several factors may have affected these findings. One reason for the lack of significant results may be that well-being was only measured by counselors’ self report. Counselors may have been reluctant to reveal personal information regarding their distress. Data from this study reveal that counselors by and large reported high levels of well-being as measured by the BHQ-20 (the mean for the sample was 3.5 out of 4, with 4 being highest level of well-being). Supervisor ratings of counselor well-being, for example, may have yielded a broader range of results, as other studies have shown (Saarnio, 2002; Valle, 1981).

The lack of findings with respect to therapists’ well-being also might be a function of the therapists’ ability to effectively manage their everyday interpersonal and intrapersonal stressors, so as not to affect their work within the therapy environment. That is, although therapists may, in fact, have experienced a low level of well-being, the role of therapist might demand that they guard against allowing one’s personal life from interfering with therapeutic work. It is worth noting that the average scores on the BHQ were quite high (3.44 out of 4.0) with little variability (90% of all average scores fell above 3.0). Thus, a possible restriction in range may have contributed to a lack of findings with respect to well-being. Given that well-being has been found to be related to treatment efficacy in
previous psychotherapy research (Beutler et al., 2004; Luborsky et al., 1985), this remains an open question requiring further investigation.

The second hypothesis was that therapists reporting stronger negative reactions towards clients would be viewed by their clients as less effective. Multivariate multiple regression analyses revealed significant results such that therapists with stronger negative reactions towards clients were indeed seen as less effective by their clients. This main effect was only found with respect to clients’ ratings of the working alliance and therapist empathy, while therapists’ emotional reactions were unrelated to session depth and counselor credibility. One way of explicating these findings would be that clients who perceive higher levels of alliance and therapist empathy receive more positive emotional reactions from their therapists. It may also be that therapists who receive more positive feedback about their effectiveness from their clients respond with more positive emotional reactions. While it may be somewhat intuitive that therapists’ negative reactions would be inversely related to clients’ ratings of the working alliance and empathy, the findings are noteworthy given that measures of therapists’ emotional reactions and effectiveness came from two different sources, the therapist and client. These findings suggest a true relational process that speaks to the therapeutic dance that occurs between two individuals during a therapeutic encounter.

Previous literature suggests that mechanisms for change in the therapeutic relationship not only necessitate that the therapist maintain sufficient support, understanding, and encouragement for the client, but the client must also be receptive to these offerings so as to profit from them (Strupp, 1973). Hence, therapists’ negative reactions may create a chasm between therapist and client, making it difficult for therapeutic conditions to be
offered and received. Countertransference research has identified therapists’ negative emotional reactions as a form of countertransference manifestations (Hayes et al., 1998), which can serve to bring the therapist and client closer together (when managed effectively by the therapist) or can lead to distance between therapist and client (when managed ineffectively). These data suggest that therapists’ negative emotional reactions may have had deleterious effects on the therapeutic encounter.

Why were differences in perceived effectiveness found as a function of therapists’ emotional reactions but not their reported well-being? Therapists’ well-being may be too distal with respect to the therapeutic encounter, something personal that therapists are able to manage effectively outside the relationship. Emotional reactions, however, provide a “here and now” proximal glimpse into the specific therapeutic encounter. That is, therapists’ reported emotional reactions were specifically tied to their clients, while therapist well-being, is much broader and may reflect a variety of non-therapy related factors. Therapists’ emotional reactions seem to be impacted by a process between therapists and clients, where the clients’ perceptions of working alliance and therapists’ empathy may be affected by and reflective of therapists’ emotional states. These findings may also reflect something germane to substance abuse counseling. Previous research has found that the nature of the client affects the strength of the emotional reactions elicited from the therapist (Imhoff, 1991). Within substance abuse counseling settings, clients can present with a range of specific defenses including hostility and provocativeness, as well as avoidance and helplessness (Imhoff, 1995). These presentations can elicit strong emotions in therapists including anger, defensiveness, inadequacy, and withdrawal (Najavits, 2001). These data may be a further indication that substance abuse clients can stir a range of
emotional reactions from the therapist, thus shaping the quality of relational patterns between therapist and client.

In the current study, effectiveness was measured across multiple dimensions including the working alliance, empathy, counselor credibility, and session depth. The majority of significant findings in the current study were realized with respect to the working alliance and empathy. While causality can not be established from the current findings, there has been generally strong empirical support for the working alliance (DiClemente et al., 2000; Luborsky et al., 1985; Wampold, 2001) and empathy (Miller & Baca, 1983; Miller, Benefield, & Tonigan, 1993; Miller et al., 1980; Miller et al., 2003) as predictors of outcome in general psychotherapy and substance abuse treatment research. Given this, it is not surprising that both working alliance and empathy emerged among the four measures of effectiveness as significant. Given the significant findings with respect to therapists’ emotional reactions and client perceptions of effectiveness, further analyses of the REACT in relation to the four measures of effectiveness were conducted. These additional analyses of the REACT’s subscales provided an additional perspective from which to evaluate the study’s main findings.

*Findings Among REACT Subscales*

The REACT has four subscales: In Conflict with Self, Focusing on Own Needs, Positive Connections, and In Conflict with Client. All except one (In Conflict with Client) were significantly related to client ratings of effectiveness using multivariate multiple regression. Therapists with higher In Conflict with Self scores were rated by their clients as having significantly lower scores on the Working Alliance Inventory. This inverse relationship implies that therapists’ internal emotional reactions may affect the treatment process as
perceived by clients, such that therapists who are struggling with internal conflicts (related to clients) may establish weaker alliances with their clients. These findings are consistent with recent countertransference research findings, such that therapists’ negative countertransference behaviors are inversely related to the quality of working alliance between client and therapist (Ligiéro & Gelso, 2002). Interestingly, some research has shown that therapists who engage in more self criticism actually are seen as more effective by their clients (Najavits & Strupp, 1994). However, self-criticism is not necessarily the same as conflict with self. Self criticism might be a function of therapists’ self awareness (Najavits & Strupp, 1994) and therefore be adaptive, while conflict with self may be more indicative of therapists’ internal angst and unresolved issues. This engenders the very definition of countertransference (Gelso & Hayes, 2002).

It is important to remember that therapists’ emotional reactions towards clients do not necessarily translate into negative therapist behavior. Previous research has found that therapists who manage their anxieties effectively and are able to conceptualize in-session therapeutic dynamics are more likely to facilitate client growth and improvement in therapy (Gelso et al., 2002). It has also been found that therapists’ empathy for clients can diffuse their countertransference reactions and increase their attunement to clients’ needs (Hayes et al., 1997). This is especially salient given the robust findings with respect to therapists’ Positive Connections subscale scores. Therapists who believed they had better connections with their clients were rated by their clients as having significantly better alliances, empathy, session depth, and credibility. These findings are consistent with the most basic conditions in therapy process harking back to Rogers (1961) who purported that the client must feel fully psychologically received just as he/she is, by the therapist. Clearly, the data
suggest that therapists reporting positive connections (e.g., compassion, fondness, and affection) with their clients were most likely displaying conspicuous behaviors that were subsequently detected by their clients. Because a causal relationship cannot be established with the present data, we must acknowledge the possibility that therapists’ positive connections result from positive client experiences, rather than the other way around. However, there are numerous studies linking therapists’ affiliative behaviors with positive client outcomes in psychotherapy research (Henry et al., 1990; Najavits & Strupp, 1994; Miller et al., 1993).

These findings are significant not only with respect to general therapy process research but also specifically within substance abuse treatment. It has been a widely held criticism that substance abuse therapists often engage in overly directive, authoritarian, and confrontational therapeutic styles (Miller et al., 1993), which can lead to poorer outcomes. Therefore, even though substance abuse clients may elicit negative reactions in therapists such as fear and avoidance (Najavits, 2001), maintaining a compassionate and caring approach may yield the most therapeutic gains. In the present study, it appears that the specific pathways through which these gains can be made are empathy and the working alliance.

With respect to the subscale Therapists Focusing on Own Needs, higher scores were negatively related to client ratings of effectiveness. While the regression model was significant, no single criterion variable was found to be significantly related to the predictor variable in the model. These results may suggest, albeit cautiously, that therapists’ negative introjective states (e.g., avoiding, recoiling, appeasing) may contribute to problematic processes (Henry et al., 1990). If so, this would be consistent with
countertransference research where findings suggest that therapists who manage their anxieties and maintain appropriate boundaries are more likely to facilitate growth and improvement with their clients (Gelso & Hayes, 2002; Gelso et al., 2002; Hayes et al., 1997).

**Prognostic Expectancy**

The third hypothesis in the study was that therapists’ prognostic expectancies would be a function of their well-being and emotional reactions towards clients. Simultaneous multiple regression did not support this hypothesis. However, therapists’ prognosis (TEI) scores were significantly correlated with therapists’ emotional reactions (REACT) scores, such that therapists’ prognostic scores were inversely related to their negative emotional reactions. Based on these correlational data, therapists with more negative reactions were likely to rate their clients’ prognostic expectancies less favorably, and those therapists with less negative reactions were likely to rate their clients’ prognostic expectancies more favorably. It has long been theorized that therapists’ expectancies of clients’ achievement can be highly influential and can at least partially determine the success of treatment (Frank & Frank, 1991). What is intriguing here is that these data suggest that therapists’ expectancy of their clients may be affected by their own emotional reactions towards these clients, or visa versa. While much of the literature suggests that therapists’ expectancy is often influenced by client variables (Leake & King, 1977), these data are suggesting an additional layer, namely that therapists’ emotional reactions towards clients may be contributing to expectancy effects.

Therapists’ prognostic expectancies were also significantly positively correlated with every client measure of effectiveness: working alliance, therapist empathy, session depth,
and counselor credibility. These correlations suggest that when therapists expected their clients’ outcomes to be more favorable, clients in turn were more likely to rate therapy as more effective. While prognostic expectancy was not hypothesized in the present study to predict clients’ perceptions of effectiveness, it is intriguing to find the significant correlations especially given that the data were generated from two separate sources. Therapist expectancy has been found in prior research to be associated with the development of a therapeutic alliance (Joyce & Piper, 1998), and has been found to account for approximately 15% of all outcome variance in summated psychotherapy research (Lambert & Barley, 2002). It appears from these correlational data that clients may be positively influenced by their therapists’ explicit or implicit expectancy regarding clients’ potential for treatment success. The direction of this relationship is unclear, however, given that therapists’ positive expectancy may be affected by clients’ positive perceptions of the therapy process.

Interaction Effects

This study intended to shed some light on the specific characteristics of substance abuse therapists with respect to their effectiveness and recovery status. While there has not been considerable research in this area with respect to therapist recovery status and its effect on treatment process, many have tried to tease out some of the salient differences between therapists in recovery and those who are not. This study examined process research, specifically exploring therapeutic dyads to examine possible differences between recovering and non-recovering counselors. Specifically, this study hypothesized that there would be an interaction effect between therapists’ recovery status and well-being, such that recovering therapists with greater well-being would be more effective than non-recovering
therapists. That is to say, those recovering therapists with higher well-being were expected to be able to utilize their recovery status as a therapeutic mechanism, thus outperforming their non-recovering counterparts (regardless of their well-being). Multivariate multiple regression did not support this hypothesis.

Given the previous significant findings with respect to the therapists’ emotional reactions and client ratings of effectiveness, additional analyses were conducted to see if there was an interaction effect between therapists’ emotional reactions and recovery status on effectiveness. Again, multivariate multiple regression did not find any significant interaction. Analyses between recovering and non-recovering therapists were conducted to see if they differed on dependent variables, but there was no difference between the two groups.

On the surface, this study confirms previous findings that there are no apparent differences in effectiveness between recovering and non-recovering counselors (Culbreth, 2000; Najavits & Weiss, 1994; Project MATCH, 1998). Additional analyses revealed no effects for therapists’ education and years of experience on clients’ perceptions of effectiveness. There are, however, some important characteristics worth mentioning with respect to this sample. The group of counselors surveyed was an extremely seasoned group professionally. All were certified as addictions counselors, had at least a bachelor’s degree, and the entire sample averaged 22 years of professional experience with only 3 participants having fewer than 10 years experience. There were virtually equal averages of education and experience for both recovering and non-recovering participants. One may gather that differences in effectiveness might have occurred if the sample consisted of more novice or early career counselors. Therefore, any potential effects for education may have
been negated by the extensive experience in this group, meaning that when both recovering and non-recovering therapists persevere in the field long enough, their differences in effectiveness equalizes. It is important to note that it is unclear what types of training these therapists received. Some research has suggested that we might be advised to assess training in terms of amount of time spent in studying treatment specific concepts and practices (Beutler et al., 2004).

Interestingly, the recovering therapists as a group had extensive time in recovery, averaging 25 years of recovery, with a range of 13 to 37 years. Analyses yielded no differences with respect to time in recovery on any of the dependent measures. Differences in effectiveness might have occurred if the sample consisted of recovering therapists with fewer years of recovery time. While there were relationships found with respect to therapists’ emotional reactions and their impact on process, these findings do not appear to be a function of recovery status, training, education level, nor experience. Furthermore, recovering and non-recovering therapists did not differ with respect to their well-being and emotional reactions. This appears to be the first study of its kind documenting so few differences between recovering and non-recovering therapists.

*Methodological Limitations*

One methodological limitation pertains to the survey design itself. Most notably, the survey was not experimental, and therefore does not permit interpretation of causality from the findings. There are also the attendant concerns regarding external validity, impacting the ability to generalize these results to broader substance abuse counseling settings. While surveys can have strong external validity in general, the low response rate (18% in present study) calls into question generalizability. While there was an excellent return rate with
respect to therapists’ clients returning packets (78%), it is not clear exactly how therapists chose their clients. While therapists were instructed to complete information and proceed to give client packets to their “next” client, without any experimenter control, therapists were free to choose their clients based on their own subjective criteria. Additionally, counselors chose only one client for participation in the study, therefore providing a singular and narrow representation of counselor behaviors in a therapeutic setting. While the original mailing resulted in far too many returns due to bad addresses (193 out of 500), impacting the actual sample size used, the final sample was able to provide a dyadic relational glimpse into the therapy process. Not only did the study provide an examination of therapists’ reactions towards their clients, but the clients were able to provide their own perceptions of the therapeutic process.

Clinical Implications

Findings from the current study suggest that therapists’ negative and positive emotional reactions towards their clients are predictive of clients’ perceptions of their therapists’ effectiveness. This has significant training implications, especially with respect to the delivery of supervision. These data suggest that it is insufficient for clinicians to develop therapeutic proficiency without proper attention to specific emotional reactions being elicited by clients. Furthermore, emotional reactions towards clients do not only pertain to those which are negative or causing interference in therapy. As the current study suggests, therapists’ positive emotional reactions aroused by their clients may affect these clients’ view of their therapists’ empathy and alliance.

Gelso and Hayes (2002) suggest that countertransference, for decades, was mostly a pejorative term, something that needed to be extinguished. Subsequently, therapists in
training would often avoid or deny their emotional reactions towards clients due to fears of harsh evaluation or concerns of personal inadequacy. It is important, therefore, to encourage and facilitate dialogue between supervisors and trainees to more fully understand and address these reactions in supervisory relationships. Attention to these therapeutic processes can enhance therapists’ ability to effectively manage negative emotional reactions, thereby minimizing disruptions to empathy and working alliance. The data also suggest that therapists’ positive emotional reactions can positively affect the therapeutic relationship. Clinical training and prevailing wisdom often warn clinicians against softening or loosening boundaries, which are intended to preserve a professional and therapeutic stance. If therapists reveal too much “liking” or “feeling close” to clients, or are seen as overly nurturing their clients, they may be warned (in supervision) that these feelings and reactions might be counter-therapeutic. These data don’t completely dispute these notions, but certainly suggest therapists can dually benefit from “managing” negative reactions towards clients, as well as “fostering” positive regard for their clients. Therapists need to be aware of these “natural” provocative processes during therapy, and utilize supervision (and possibly personal therapy) to effectively manage and possibly capitalize on these in-therapy experiences. Developing countertransference management skills takes on added importance based on the current study’s findings. These factors include therapist proficiency in self integration, anxiety management, conceptualizing skills, empathy, and self-insight (Hayes et al., 1991). When used constructively, these skills can enhance the therapeutic relationship between therapist and client, thereby benefiting clients’ experience of therapy. In light of the current study’s findings, these skills appear to be much more
salient in developing effective therapeutic relationships, and could be a facilitative tool in supervision.

In substance abuse training environments, therapists are often encouraged to be directive and confrontational given the complex array of client defenses such as denial, resistance, and minimization that often accompany substance abuse disorders (Miller et al., 1993). These data suggest that a warm, supportive, and non-directive approach in substance abuse treatment settings can positively affect therapeutic process.

Summary of Findings

Therapists’ well-being, emotional reactions towards clients, and therapists’ recovery status were examined to determine if these variables predict specific process variables, including client reports of therapist empathy, the working alliance, session depth, and therapist credibility. Significant relationships were found between therapists’ positive and negative emotional reactions and client ratings of therapist empathy and the working alliance. Therapists’ prognostic expectancies were associated with therapists’ emotional reactions and clients’ ratings of effectiveness in expected ways. Therapists’ well-being did not predict clients’ ratings on any of the dependent variables. Furthermore, there were no differences between recovering and non-recovering therapists on any dependent variables, nor did recovery status interact with well-being to predict any of the dependent variables.

Future Directions

Replication with a larger sample stands out as one of the more important directions to consider in future research. Larger samples might capture a broader and more diverse representation (length of recovery, education, types of training) of therapists with better chances of understanding the unique contributions of recovering therapists. Increasing
experimental control, thereby providing evidence into the possible causal relationships between therapists’ emotional reactions and treatment outcomes, may be accomplished through alternative methodological designs. This may be accomplished by bringing therapists into a more controlled laboratory setting, allowing for manipulation of specific variables. Future research should also focus on providing a more direct link between therapist variables (e.g., emotional reactions) and specific client outcomes such as drop out rates, drinking habits, work functioning, interpersonal relationships, and other psychosocial measures. Additionally, examining these variables within the context of current empirically supported treatments in substance abuse such as Motivational Interviewing (Miller & Rollnick, 2002) may be beneficial given Motivational Interviewing’s use of empathic approaches. Subsequently, therapists’ attunement to their emotional reactions may facilitate more effective implementation of specific treatment approaches. This may be fruitful given that the literature consistently shows that variability in success rates has as much or more to do with the therapist rather than the type of treatment (Beutler et al., 2004; Luborsky et al., 1985; Wampold, 2001).

While there were apparently no differences between recovering and non-recovering therapists in the current study, it is still important to examine different processes employed between the two groups. Recovering therapists can provide a resource for future research, examining how recovering therapists manage their own history of wounds, and how they utilize these personal histories in their clinical work. This may need to be done through qualitative research so as to capture specific themes that can build upon and expand existing theory.
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Najavits, L. M., & Strupp, H. H. (1994). Differences in the effectiveness of


Rodriguez de la Sierra, L. (2002). Countertransference: Our difficulties in the treatment of


Appendix A

Return Address

Dear Mr./Ms.,

We are writing to request your participation in a research project that we will be conducting in the near future. This study is affiliated with the Pennsylvania State University and has been approved by the Social Science Institutional Review Board. We have planned a survey of nationally certified substance abuse professionals. You are one of a small group of professionals selected as a potential participant in this study. Your involvement would be extremely helpful and greatly appreciated.

We know that your time is highly valuable, so we have intentionally kept the survey as concise as possible. As a small token of our appreciation, we will enter your name in a drawing to receive one of ten $25 gift certificates to Amazon.com when we receive your completed survey. We will also be donating $1.00 to the Hazelden Foundation for every completed packet returned. While we recognize that $1.00 is a minimal amount of money to recognize your efforts, we hope that sufficient participation will result in a meaningful contribution.

The study contains several demographic items and three brief measures, all of which should take no longer than 10 to 20 minutes. In addition, we will include a packet that we would ask you to give to your next client with whom you are working in a substance abuse setting, or a client with whom you are working experiencing substance abuse problems. All responses to the survey will be strictly confidential. Due to the nature of the survey, if you do not possess at least a bachelor’s degree or are not working with clients who have substance abuse problems, we would like to not bother you with subsequent mailings. Kindly email Michael C. Wolff at mxw102@psu.edu if you do not meet the criteria for participating in this study.

We would be extremely grateful if you would consider participating in this study. We will be sending you the brief survey in the next week or so. If you have any questions, concerns, or comments, please feel free to call Michael C. Wolff at (814) 863-5659, or email at mxw102@psu.edu. Thank you in advance for your help.

Sincerely,

Michael C. Wolff MA, CAC  (Certified Addictions Counselor)

Doctoral Candidate in Counseling Psychology

Jeffrey A. Hayes, Ph.D.
Associate Professor of Counseling Psychology
Phone: 814-863-3799    Email: jxh34@psu.edu
Appendix B

Dear Mr./Ms.,

We are writing to request your help with a research project we are conducting. We are investigating substance abuse counselors and their experiences in their work and profession. Your participation as one of a small group of selected professionals would be extremely helpful and greatly appreciated.

Enclosed you will find a one page survey with several demographic items and three brief questionnaires, all of which should take no longer than 10-20 minutes. We would be grateful if you would complete all the questions in this survey and mail it back to us in the postage-paid envelope that is provided. Additionally, there are two questionnaires that ask questions about a particular client. Please choose the next client you are working with (if possible) in a substance abuse setting and then please give that particular client the client packet. Please consider that client when you complete the enclosed questionnaires. We are also enclosing a client packet, which we would request that you give to your identified adult client (i.e., 18 years or older) with whom you are addressing substance abuse related problems. Please ask your client to complete the brief questionnaires and return them to us in the postage-paid envelope provided in the client packet. Your client’s responses should be returned separately from your own. We know that your time is highly valuable, so we have intentionally kept the survey as concise as possible. Would you please consider taking 10-20 minutes to complete the survey and ask a client to participate as well? As a small token of our appreciation, we will enter your name in a drawing to receive one of ten $25 gift certificates to Amazon.com when we receive your completed survey. We will also be donating $1.00 to the Hazelden Foundation for every completed packet returned. While we recognize that $1.00 is a minimal amount of money to recognize your efforts, we hope that sufficient participation will result in a meaningful contribution.

Please know that all of your responses will be strictly confidential. The survey asks for no personally identifying information, and a code will be our only method of tracking responses. Codes will be used to pair counselor and client responses, and to keep track of respondents so that we do not burden you with unnecessary follow-up mailings. If you would like to receive a summary of our findings, you may indicate this on the survey. If you wish, we will inform you of the results of the study as soon as they are available.

*You are being asked to participate in a study that asks questions regarding your personal history, feelings, behaviors, and expectancies with respect to your clients. This may cause some discomfort although you are free to review specific materials prior to completing them. Your completion of these materials will assist in providing insight into the effectiveness of counseling, and you may find that completion of materials will increase your professional awareness.

This research has been reviewed and approved by the Institutional Review Board at The Pennsylvania State University (IRB Number: 19259). This study involves no known risks or discomforts and your participation in the study is entirely voluntary. You must be at least 18 years of age to participate in this study. You may decline to answer any specific survey questions or withdraw your participation in this study at any point in time. Your completion and return of the enclosed survey constitutes provision of informed consent. If you have any questions or concerns about the study, please feel free to call Michael C. Wolff at (814) 863-5659 or email questions to mw102@psu.edu. If you have questions about your rights as a research participant, you may contact Penn State’s Office for Research Protections at (814) 865-1775. The Office for Research Protections and the Social Science Institutional Review Board may review records related to this project.

We are grateful for your willingness to consider participating in this study. You participation in the study will help us further the body of knowledge in this important area of research.

Sincerely,

Michael C. Wolff MA, CAC (Certified Addictions Counselor)
Doctoral Candidate in Counseling Psychology

Jeffrey A. Hayes Ph.D.
Associate Professor of Counseling Psychology

Phone: 814-863-3799   Email: jxh34@psu.edu

This informed consent form was reviewed and approved by the Social Science Institutional Review Board at The Pennsylvania State University on April 1, 2005. It will expire on August 11, 2005. (IRB# 19259 Doc. #1 - J. Mathieu)
Appendix C

Date

Return Address

Dear Mr./Ms.,

Recently we wrote to you asking for your help in a research project we are conducting on substance abuse counseling. Because we have not received your completed survey, we are writing now to see if you would consider completing our short survey. We are only sampling a small group of substance abuse professionals, so your response is crucial to ensuring a representative sample. If you have already returned your completed survey, please accept our sincere thanks for your time. If you have not yet completed the survey, would you please consider taking a few minutes to fill it out? Should you need a replacement copy, feel free to contact Michael C. Wolff or Dr. Jeffrey Hayes at (814) 863-5659 (email: mxw102@psu.edu), or (814) 863-3799; we would be happy to send you one. Thank you again for your help.

Sincerely,

Michael C. Wolff  MA, CAC
Doctoral Candidate in Counseling Psychology

Jeffrey A. Hayes, Ph.D.
Associate Professor of Counseling Psychology
Appendix D
Final Follow-up Letter to Counselors

Dear Mr./Ms.

We are writing one final time to request your help with a research project we are conducting on substance abuse counseling.

Enclosed you will find a one-page survey with several demographic items and three brief questionnaires, all of which should take no longer than 10-20 minutes. We would be grateful if you would complete all the questions in this survey and mail it back to us in the postage-paid envelope that is provided. Additionally, there are two questionnaires that ask questions about a particular client. Please choose the next client you are working with (if possible) in a substance abuse setting and then please give that particular client the client packet. Please consider that client when you complete the enclosed questionnaires. We are also enclosing a client packet, which we would request that you give to your identified adult client (i.e., 18 years or older) with whom you are addressing substance abuse related problems. Please ask your client to complete the brief questionnaires and return them to us in the postage-paid envelope provided in the client packet. Your client’s responses should be returned separately from your own. We know that your time is highly valuable, so we have intentionally kept the survey as concise as possible. Would you please consider taking 10-20 minutes to complete the survey and ask a client to participate as well? As a small token of our appreciation, we will enter your name in a drawing to receive one of ten $25 gift certificates to Amazon.com when we receive your completed survey. We will also be donating $1.00 to the Hazelden Foundation for every completed packet returned. While we recognize that $1.00 is a minimal amount of money to recognize your efforts, we hope that sufficient participation will result in a meaningful contribution.

Please know that all of your responses will be strictly confidential. The survey asks for no personally identifying information, and a code will be our only method of tracking responses. Codes will be used to pair counselor and client responses, and to keep track of respondents so that we do not burden you with unnecessary follow-up mailings. If you would like to receive a summary of our findings, you may indicate this on the survey. If you wish, we will inform you of the results of the study as soon as they are available.

*You are being asked to participate in a study that asks questions regarding your personal history, feelings, behaviors, and expectancies with respect to your clients. This may cause some discomfort although you are free to review specific materials prior to completing them. Your completion of these materials will assist in providing insight into the effectiveness of counseling, and you may find that completion of materials will increase your professional awareness.

This research has been reviewed and approved by the Institutional Review Board at The Pennsylvania State University (IRB Number: 19259). This study involves no known risks or discomforts and your participation in the study is entirely voluntary. You must be at least 18 years of age to participate in this study. You may decline to answer any specific survey questions or withdraw your participation in this study at any point in time. Your completion and return of the enclosed survey constitutes provision of informed consent. If you have any questions or concerns about the study, please feel free to call Michael C. Wolff at (814) 863-5659 or email questions to mxw102@psu.edu. If you have questions about your rights as a research participant, you may contact Penn State’s Office for Research Protections at (814) 865-1775. The Office for Research Protections and the Social Science Institutional Review Board may review records related to this project.

We are grateful for your willingness to consider participating in this study. Your participation in the study will help us further the body of knowledge in this important area of research.

Sincerely,

Michael C. Wolff MA, CAC (Certified Addictions Counselor)
Doctoral Candidate in Counseling Psychology

Jeffrey A. Hayes Ph.D.
Associate Professor of Counseling Psychology
Phone: 814-863-3799 Email: jxh34@psu.edu

This informed consent form was reviewed and approved by the Social Science Institutional Review Board at The Pennsylvania State University on April 1, 2005. It will expire on August 11, 2005. (IRB# 19259 Doc. #2 - J. Mathieu)
Appendix E

Demographic Form (Counselor)

Please answer the following questions fully and to the best of your ability. Your honesty is appreciated and valued. When finished, please submit this form along with the other questionnaires that you complete. Thanks for your time and cooperation!

Background:

Age: ______ Gender: ______

Ethnicity: ___________

Education:

Highest Degree earned: __________

Are you certified as a drug and alcohol counselor? ______

Field Experience:

Years of counseling experience: __________

Work Setting: ____________ (e.g., hospital/inpatient, detox, outpatient clinic, private practice, etc.)

Theoretical Orientation: ____________

Personal Experience:

Would you describe yourself as being in recovery? ____________

If so, approximately how many years have you been in recovery? ____________

Would you like to receive a summary of this study’s findings? Yes No
Appendix F

We are writing to request your help with a research project we are conducting. We are investigating the effectiveness of counseling in substance abuse. Your counselor has given you this packet because you are receiving this kind of counseling, and we would greatly appreciate your input. We recognize that your time is valuable, so we have intentionally kept the study as brief as possible. Would you please consider taking 10 to 15 minutes to complete the questionnaires?

Enclosed you will find two pages consisting of demographic items and three questionnaires regarding your relationship with your counselor and the counseling you are receiving. Please complete both sides of each page and return the completed survey in the postage-paid envelope provided.

Please know that all of your responses will be strictly confidential. The survey asks for no personally identifying information; only a code will be used to track responses. Your counselor will not have access to your survey responses. Your decision to participate or not participate in this study will not affect your relationship with your counselor or the counseling you are receiving.

This research has been reviewed and approved by the Institutional Review Board at The Pennsylvania State University (IRB# 19259). This study involves no known risks or discomforts and your participation in the study is entirely voluntary. You must be 18 years of age or older to participate in the study. You may decline to answer any specific survey questions or withdraw your participation in this study at any point in time. Your completion and return of the enclosed survey constitutes provision of informed consent. For questions or comments about the study, please feel free to contact Michael C. Wolff, MA, CAC 814-863-5659 (email: mxw102@psu.edu). If you have questions about your rights as a research participant, you can contact the Office for Research Protections at 814-865-1775. The Office for Research Protections and the Social Science Institutional Review Board may review records related to this project.

*You are being asked to participate in a study that asks questions regarding your thoughts and feelings with respect to your counselor and counseling experience. This may cause some discomfort although you are free to review specific materials prior to completing them. Your completion of these materials will assist in providing insight into the effectiveness of counseling, and you may find that completion of materials will increase your awareness with respect to your counseling experience. Completion and return of the survey is considered consent to participate in this research.

Thank you in advance for your willingness to complete the enclosed survey.

Sincerely,

Michael C. Wolff  MA, CAC (Certified Addiction Counselor)
Doctoral Candidate in Counseling Psychology

Jeffrey A. Hayes, Ph.D.
Associate Professor of Counseling Psychology
Phone: 814-863-3799   Email: jxh34@psu.edu

This informed consent form was reviewed and approved by the Social Science Institutional Review Board at The Pennsylvania State University on April 1, 2005. It will expire on August 11, 2005. (IRB# 19259 Doc. #3 - J. Mathieu)
### Behavioral Health Questionnaire (Intake) (BHQ-20)

Please answer these questions as they relate to the past two weeks.

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating Options</th>
<th>Score Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How distressed have you been?</td>
<td>Extremely distressed, Very distressed, Moderately distressed, A little bit distressed, Not at all distressed</td>
<td>0, 1, 2, 3, 4</td>
</tr>
<tr>
<td>2. How satisfied have you been with your life?</td>
<td>Not satisfied at all, Mildly satisfied, Somewhat satisfied, Satisfied, Very Satisfied</td>
<td>0, 1, 2, 3, 4</td>
</tr>
<tr>
<td>3. How energetic and motivated have you been feeling?</td>
<td>Not at all energetic, A little bit energetic, Somewhat energetic, Energetic, Very energetic</td>
<td>0, 1, 2, 3, 4</td>
</tr>
</tbody>
</table>

Please use the following rating scale for questions #4 to #16. In the past two weeks, ( ), how much have you been distressed by:

- Feeling fearful, scared.
- Alcohol/drug use interfering with your performance at school or work.
- Wanting to harm someone.
- Not liking yourself.
- Difficulty concentrating.
- Eating problem interfering w/ relationships w/ family &/or friends.
- Thoughts of ending your life.
- Feeling sad most of the time.
- Feeling hopeless about the future.
- Powerful, intense mood swings (highs and lows).
- Alcohol/drug use interfering with your relationships with family and/or friends.
- Feeling nervous.
- Heart pounding or racing.

Please use the following rating scale for questions #17 to #20. How have you been getting along in the following areas of your life over the past two weeks ( ):

- Very well.
- Well.
- Fair.
- Poorly.
- Terribly.

**TOTAL SCORE:**

**MEAN SCORE:**

(Questions 1 - 20)

---

Appendix G

**Behavioral Health Questionnaire (Intake) (BHQ-20)**

Please answer these questions as they relate to the past two weeks.

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating Options</th>
<th>Score Options</th>
</tr>
</thead>
<tbody>
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<td>0, 1, 2, 3, 4</td>
</tr>
<tr>
<td>2. How satisfied have you been with your life?</td>
<td>Not satisfied at all, Mildly satisfied, Somewhat satisfied, Satisfied, Very Satisfied</td>
<td>0, 1, 2, 3, 4</td>
</tr>
<tr>
<td>3. How energetic and motivated have you been feeling?</td>
<td>Not at all energetic, A little bit energetic, Somewhat energetic, Energetic, Very energetic</td>
<td>0, 1, 2, 3, 4</td>
</tr>
</tbody>
</table>

Please use the following rating scale for questions #17 to #20. How have you been getting along in the following areas of your life over the past two weeks: Very well, Well, Fair, Poorly, Terribly.

**TOTAL SCORE:**

**MEAN SCORE:**

(Questions 1 - 20)
Please answer the following questions based on the client you have given the packet to.

**THERAPISTS:** Please fill out below how you currently feel about your patient, overall.

We recognize that such ratings may seem personal but keep in mind that at no time will you as an individual be identified in write-ups of the findings. Also, please note that no answers are viewed as "right" or "wrong".

Circle your rating for each item

<table>
<thead>
<tr>
<th>FEELINGS</th>
<th>Never</th>
<th>Seldom</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very Often</th>
<th>Can't Say</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Optimistic about patient's future</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>2 &quot;Burned out&quot; with this patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>3 Wishing to nurture, protect, take care of this patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>4 A sense of overinvolvement (&quot;stickiness&quot;) with the patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>5 Drained and exhausted</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>6 A sense of connection or attachment to the patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>7 Power struggles with this patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>8 Overwhelmed by the severity of patient's problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>9 Intellectually stimulated by this patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>10 Good (gratified) about the work with this patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>11 Concerned about the patient's suicidal or homicidal impulses</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>12 Empathy, sympathy, or compassion</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>13 Frustrated</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Feelings</th>
<th>Never</th>
<th>Seldom</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very Often</th>
<th>Can't Say</th>
</tr>
</thead>
<tbody>
<tr>
<td>14 Manipulated or used by the patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>15 Threatened, intimidated or frightened by the patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>16 Tolerant and understanding</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>17 Insufficiently paid (financially) for working with this patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>OB (9)</td>
</tr>
<tr>
<td>18 Guilty, with a sense that you may be doing something &quot;wrong&quot; or should do &quot;more&quot;</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>19 Satisfied with your therapeutic efforts with this patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>20 Sexual attraction for this patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>21 Helpless in relation to the patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>22 Identification with the patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>23 Provoked or angered by the patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>24 Wishing to withdraw from contact with the patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>25 Experiencing tension and division in the staff in relation to the patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>26 Confused about the patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>27 Cautious or uneasy about confronting or setting limits with the patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>28 Doubting my competence in relation to the patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>29 Disappointment with the patient or the patient's treatment</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>30 Strong dislike or hate toward this patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>31 Appreciated by the patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>32 Worried about the patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>33 Bored with the patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>34 Liking, fondness, affection for the patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>FEELINGS</td>
<td>Never</td>
<td>Seldom</td>
<td>Sometimes</td>
<td>Often</td>
<td>Very Often</td>
<td>Can't Say</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-------</td>
<td>--------</td>
<td>-----------</td>
<td>-------</td>
<td>------------</td>
<td>-----------</td>
</tr>
<tr>
<td>35 Blaming the patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>36 Stress working with the patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>37 Enjoyment with the patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>38 Thought about the patient outside of sessions</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>39 Had dreams about the patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>40 (Write in and rate any additional feelings you notice:)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How often has your patient:</th>
<th>Never</th>
<th>Seldom</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very Often</th>
<th>Can't Say</th>
</tr>
</thead>
<tbody>
<tr>
<td>41 Discussed a wish to change to a different therapist or treatment</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>42 Left a session before it was over</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
<tr>
<td>43 Mentioned wanting to end treatment altogether (for any reason). Stated reason:</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>CS (9)</td>
</tr>
</tbody>
</table>

44. TREATMENT EXPECTATION: I predict that this patient will remain in treatment with me for ____ more sessions (fill in the number).

Any suggestions or improvements on this measure? Please write them below or on back.
Appendix I

PLEASE ANSWER WITH RESPECT TO THE CLIENT YOU HAVE GIVEN THE
PACKET TO

Therapist Expectancy Inventory

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>4</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not expect at all</td>
<td>Moderately Expect</td>
<td>Greatly Expect</td>
</tr>
</tbody>
</table>

The following questions reflect some potential outcomes for clients. Please answer the following questions with respect to the client who is participating in the study. Please use the scale above and answer each question in the space provided.

1) After intervention, this client will have a better idea of personal strengths and weaknesses.
   
   RESPONSE

2) After intervention, this client will have better self-management strategies.

   RESPONSE

3) After intervention, this client will be able to make decisions based more on inner feelings than on outside pressures.

   RESPONSE

4) After intervention, this client will make more effective decisions.

   RESPONSE

5) After intervention, this client will have become more effectively assertive.

   RESPONSE

6) After intervention, this client will experience more self-acceptance.

   RESPONSE

7) After intervention, this client will have a greater self-knowledge.

   RESPONSE

8) After intervention, this client will be less bothered by criticism.

   RESPONSE

9) After intervention, this client will be able to communicate more easily with significant others.

   RESPONSE
Appendix J

Barrett-Lennard Relationship Inventory

Listed below are a variety of ways that one person may feel or behave in relation to another person. Please consider each statement with reference to your present relationship with your counselor. Mark each statement in the left margin, according to how strongly you feel that it is true, or not true, in this relationship. Please mark each item. Write in +3, +2, +1, or -1, -2, -3, to stand for the following answers:

+3: Yes, I strongly feel that it is true.
+2: Yes, I feel it is true.
+1: Yes, I feel that it is probably true, or more true than untrue.
-1: No, I feel that it is probably untrue, or more untrue than true.
-2: No, I feel it is not true.
-3: No, I strongly feel that it is not true.

1. My counselor usually senses or realizes what I am feeling.
2. My counselor reacts to my words but does not see the way I feel.
4. My counselor's own attitude toward things I do or say gets in the way of understanding me.
5. My counselor realizes what I mean even when I have difficulty in saying it.
6. My counselor usually understands the whole of what I mean.
7. My counselor does not understand me.
8. My counselor appreciates exactly how the things I experience feel to me.
9. My counselor's response to me is so fixed and automatic that I don't get through to him/her.
10. My counselor doesn't listen and pick up on what I think and feel.
Appendix K

WAI

Listed below are sentences that describe some of the different ways you might think or feel about your counselor. Please respond to the statements using the following scale:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>Rarely</td>
<td>Occasionally</td>
<td>Sometimes</td>
<td>Often</td>
<td>Very Often</td>
<td>Always</td>
</tr>
</tbody>
</table>

If the statement describes how you always feel or think, write the number 7 in the blank to the left of the statement; if it never applies to you, write in the number 1. Use the other numbers to describe variations between these extremes. There are no right or wrong answers. While your thoughts or feelings about your counselor may change over time, we would like to know your views as of right now. Know that your responses are confidential and will not be shared with your counselor. Thanks again for your help.

**1.** My counselor and I agree about the things I will need to do in therapy to help improve my situation.

**2.** What I am doing in therapy gives me new ways of looking at my problem.

**3.** I believe my counselor likes me.

**4.** My counselor does not understand what I am trying to accomplish in therapy.

**5.** I am confident in my counselor’s ability to help me.

**6.** My counselor and I are working towards mutually agreed upon goals.

**7.** I feel that my counselor appreciates me.

**8.** We agree on what is important for me to work on.

**9.** My counselor and I trust one another.

**10.** My counselor and I have different ideas on what my problems are.

**11.** We have established a good understanding of the kind of changes that would be good for me.

**12.** I believe the way we are working with my problem is correct.
Appendix L

Session Evaluation Questionnaire

Please mark the space on each scale that best reflects how you tend to view sessions with your counselor.

Please place marks in the middle of the spaces.

Deep [ ] [ ] [ ] [ ] [ ] Shallow

Valuable [ ] [ ] [ ] [ ] [ ] Worthless

Full [ ] [ ] [ ] [ ] [ ] Empty

Powerful [ ] [ ] [ ] [ ] [ ] Weak

Special [ ] [ ] [ ] [ ] [ ] Ordinary

Demographic Form (Client)

Please answer the following questions fully and to the best of your ability. Your honesty is appreciated and valued. When finished, please submit this form along with the other questionnaires that you complete. Thanks for your time and cooperation!

Background:

Age: _____ Gender: ______

Ethnicity: ___________

Counseling:

Approximately, for how many sessions have you been working with your current counselor? _______
Appendix M
Counselor Rating Form – Short Version

Directions: Below you will find that each characteristic is followed by a seven point scale that ranges from “not very” to “very.” Please mark and “X” at the point on the scale that best represents how you view your therapist/counselor.

Friendly
Not very____: _____: _____: _____: _____: _____: _____ Very

Likeable
Not very____: _____: _____: _____: _____: _____: _____ Very

Sociable
Not very____: _____: _____: _____: _____: _____: _____ Very

Warm
Not very____: _____: _____: _____: _____: _____: _____ Very

Experienced
Not very____: _____: _____: _____: _____: _____: _____ Very

Expert
Not very____: _____: _____: _____: _____: _____: _____ Very

Prepared
Not very____: _____: _____: _____: _____: _____: _____ Very

Skillful
Not very____: _____: _____: _____: _____: _____: _____ Very

Honest
Not very____: _____: _____: _____: _____: _____: _____ Very

Reliable
Not very____: _____: _____: _____: _____: _____: _____ Very

Sincere
Not very____: _____: _____: _____: _____: _____: _____ Very

Trustworthy
Not very____: _____: _____: _____: _____: _____: _____ Very
Curriculum Vita

Michael C. Wolff

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Professional License/Certification:
Certified Addiction Counselor (PA-3646)

Professional Interests:
Substance Abuse Treatment, Process Variables and Substance Abuse Treatment Staff,
Working Alliance, Community-Based Consultation

Academic Preparation:
Fall 2001 to Spring 2006  Pennsylvania State University (University Park, PA)
Doctorate in Counseling Psychology
1995-1997   Antioch New England Graduate School (Keene, NH)
Master of Arts in Counseling Psychology
1986-1990   Pennsylvania State University (University Park, PA)
Bachelor of Science in Psychology

Professional Experience:
1998 to Present  Pennsylvania State University (University Park, PA)
Coordinator of Community-Based Programs/ Clinical Supervisor
Community Outpatient Psychological Clinic
2004-2005  Pennsylvania State University (University Park, PA)
Pre-doctoral Intern/Counseling and Psychological Services
5/97 to 7/98  Community Services Group Inc. (Lewistown, PA)
Program Director
Community Children’s Mental Health Service Program
6/95 to 5/97  Marathon of Brattleboro (Brattleboro, VT)
Director of Halfway House, and Outpatient Therapist
Substance Abuse Treatment Agency

Posters/Presentations:
Fall 2002  Avrumson, R., Franz, S., Wolff, M., Meyers, D., South, J., & Hayes, J. A.
Poster session presented at the fall meeting of the Society for Psychotherapy Research, State College, PA.

Teaching Experience:
Fall 2003/Sp.2004/Fall 2005  Psy 474 - Psychology of Exceptional Child (Child Psychopathology)
Instructor
Spring 2006  Psy 436 - Mental Health in Schools (Childhood Interventions)
Instructor

Community Service/Volunteer:
1999 to Present  Special Olympics of Centre County
Head Coach (Tennis), Management Team Member