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Countertransferential Reactions of Therapists as a Function of Dependency and Self-Criticism: A Schema-Theory Perspective

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Countertransferential Reactions of Therapists as a Function of Dependency and Self-Criticism: A Schema-Theory Perspective

by

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Countertransferential Reactions of Therapists as a Function of Dependency and Self-Criticism: A Schema Theory Perspective

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In describing a supervision model for Schema-Focused Cognitive Therapy (Young, 1990), Greenwald and Young (1998) suggest supervisors guide the supervisee in examining the role of his/her own schemata in the therapy process. Surprisingly, no known research has examined the role of self-schemata in therapists and how therapists' schemas might influence countertransference.

Viewed from a social cognitive perspective, therapist and client engage in a social relationship in which both individuals make interpretations of therapy experiences based on activation of personal constructs. Clients' affect, behavior, and presenting issues act as stimuli to be filtered through the therapist's schemata. Certain kinds of client material may cause a therapist's personal constructs or schemata to become activated, thereby influencing the therapist's responses in therapy.

Research on therapist expertise suggests that "healthy perspective on their

sense of importance" and "strong relationship skills" are essential qualities of effective therapists (Jennings & Skovholt, 1999, p.7). Therefore, it seems plausible that therapists' management of dependency and self-criticism schemata (c.f., Blatt, 1974; Beck, 1983) plays some role in therapists' overall efficacy. While most research has explored associations between these self-schemata and cognitive vulnerability to depression, more recent investigations are exploring how these schemas may be related to personality disorders, selection of romantic partners, and the therapeutic alliance. This dissertation examined countertransference from a schema theory perspective, specifically, therapists' affective, behavioral, and cognitive reactions to clients' dependency and self-critical issues, as a function of therapists' own dependency and self-criticism schemata. Fifty therapists listened to audiotaped vignettes of clients illustrating dependency and self-criticism issues. Affective measures included degree of warmth and anxiety felt toward each client. Behavioral measures included verbal responses made to each client. Cognitive measures included therapists' recall of information presented in the vignettes and beliefs regarding clients' treatment outcome and goals.

Linear regression analyses suggest therapists' dependency schemas predict therapists' tendency to provide verbal responses that discourage exploration of dependency-oriented issues. This study also suggests therapists' dependency schemas are associated with a tendency to under-recall dependency - oriented client

material and belief that dependency issues should receive less focus in treatment. Implications for training, supervision, and future research directions are discussed.

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Introduction

In describing a supervision model for Schema-Focused Cognitive Therapy (Young, 1994), Greenwald and Young (1998) suggest supervisors guide the supervisee in examining the role of his/her own schemata in the therapy process. Surprisingly, no known research has examined the role of self-schemata in therapists. It is reasonable to expect that therapists' schemas might interact with client issues to influence therapists' verbal responses to clients, affective arousal, and cognitive processes in therapy.

This study explored countertransference, specifically dependency and self-criticism schemata, from a schema theory perspective. Researchers from several theoretical perspectives have explored these particular schemas in depression and interpersonal processes. "Dependency" or "sociotropy" is manifested by unsatisfying interpersonal interactions (c.f. Beck, 1983), and "autonomy" or "self-criticism" is manifested by preoccupation with attaining personal achievement (c.f. Blatt, D'Afflitti, & Quinlan, 1976). Research examining these dysfunctional belief systems has given the most attention to cognitive vulnerability to depression, but more recent investigations are exploring how these subtypes are related to personality disorders, selection of romantic partners in adulthood, and the therapeutic alliance. Recently, theorists have suggested excessive self-criticism and poor interpersonal style may impede a client's experience in psychotherapy.

Psychotherapy is a social interaction made up of interpretations from both therapist and client, yet no known research has explored the role of personal

constructs in this context. Viewed from a social cognitive perspective, therapist and client engage in a social relationship in which both individuals make interpretations of therapy experiences based on activation of personal constructs. Clients' affect, behavior, and presenting issues act as stimuli to be filtered through the therapist's schemata. Certain kinds of client material might lead the therapist's personal constructs or schemata to become activated, thereby influencing the therapist's responses in therapy. Client material may differentially predict reactions in therapists, and individual differences among therapists may exist surrounding the kinds of stimuli which activate schemata in therapists.

Young (1990) suggests individuals engage in cognitive distortion or self-defeating behavior patterns in an effort to reinforce or maintain schemas. If activated within the therapy relationship, therapists' dependency or self-criticism schemata might guide therapists to interact in ways that reinforce or maintain these schemata. In an in-depth review of recent countertransference research, Hayes and Gelso state "L]ying at the very heart of countertransference is the concept of distortion" (p.1045, 2001), therefore activation of therapists' schemata and efforts to maintain the schemata might be associated with the notion of distortion drawn from theories of countertransference. As a result of distortion in the therapeutic relationship, therapists' conscious and unconscious responses to clients might be influenced on multiple levels.

Research on therapist expertise suggests that a "healthy perspective on their sense of importance" and "strong relationships skills" are essential qualities of effective therapists (Jennings & Skovholt, 1999, p. 7). Therefore, it seems plausible that therapists' management of dependency and self-criticism schemata plays some

role in therapists' overall efficacy. Given the emphasis placed on self-confidence and relational skills of effective therapists, it is possible that activation of therapists' schemata in response to clients' dependency or self-criticism issues influences the course of therapy.

This dissertation examined therapists' affective arousal, cognitive responses, and behavior in response to clients' dependency and self-criticism issues as a function of therapists' own dependency or self-criticism schemata. Of particular interest was what cognitive, affective, and behavioral responses therapists show when confronted with clients presenting schema-congruent dependency or self-criticism issues.

Chapter 1:

Review of the Literature

COUNTERTRANSFERENCE: A SCHEMA THEORY PERSPECTIVE

What is a Schema?

Since its rise with cognitive psychology in the late 1960s and 1970s, schema theory has been applied to scientific investigations concerning memory, concept representation, problem solving, movement, language, psychopathology, and psychological theory (Stein & Young, 1992). Numerous theorists and researchers have defined the schema concept and have explored several psychological problems from this perspective.

Rumelhart (1984), one of the most prominent schema theorists, suggests the schema is a knowledge structure that guides our interpretations of social interactions, objects, and understanding of events. These knowledge structures are stored in memory, and symbolize basic to very complex concepts and ideas. Rumelhart (1984) also suggests the schema is comprised of several intricate relationships or more complex knowledge structures which further facilitate processing or interpretation of objects, ideas, concepts, or actions. Schemas play a central role in how the individual both receives and reacts to stimuli in his/her environment as they organize and process incoming stimuli, integrate data from memory sources, manage actions, and set short and long-term goals for the individual (Rumelhart, 1984).

Other theorists have explored the role of schemata in psychological functioning and continue to expand descriptions of this concept. For example, in his work on memory of narratives, Bartlett (1932) defined schemata as an "active organization of past reactions or experiences that operates in a well-adapted organic response" (p. 7). Piaget (1952) examined psychological foundations of schemata, outlining their evolvement throughout cognitive stages of development. Others such as Beck (1967,1976, 1979) used schema theory to conceptualize and treat depression, which is explored in the next section.

Depression from a Schema-Theory Perspective

In constructing his cognitive theory of depression, Aaron Beck (1967, 1979) made major contributions to the understanding of depression by applying schema theory to the understanding of this disorder. Beck's cognitive theory of depression introduces the notion of a "cognitive organization" comprised of longstanding cognitive structures believed to play a central role in enduring interpretations of the environment. More specifically, Beck (1967) refers to a cognitive structure as a schema and emphasizes the importance of the schema in conceptualizing our emotional experience:

> A schema is a structure for screening, coding, and evaluating the stimuli that impinge on the organism. It is the mode by which the environment is broken down and organized into its many psychologically relevant facets. On the basis of the matrix of schemas, the individual is able to orient himself in relation to time and space and to categorize and interpret his experiences in a meaningful way. (p. 283)

Beck suggests that the schema serves as a model from which stimuli can be simplified and shaped into cognition; and that thoughts formed following activation

of the schema may be in the form of internal messages or messages to the outside world. Schemata are an integral part of cognitive functioning as they create enduring themes in both direct communication with our world and our "free associations, daydreams, ruminations and dreams" (Beck, 1967, p. 283).

The contents of schemata usually reflect beliefs, attitudes, goals and values central to that person (Beck, 1967). The schema can either be a simple or complex structure, such as a schema for the contour of a shoe or a schema for interpersonal interactions with authority figures. Schemas based on overgeneralization or distortion of previous life experiences may negatively impact future appraisals, leading to maladaptive behavior and emotional distress. Schemas may also become latent and have no effect on cognition, yet become energized when specific environmental stimuli are present (Beck, 1967).

As a result of Beck and colleagues' work (1967, 1976, 1979), several cognitive theorists have been inspired to explore dysfunctional schemata specific to depression. More specifically, researchers have examined autonomy and sociotropy schemata related to depression (c.f. Hammen, Marks, Mayo, & deMayo, 1985; Nelson, Hammen, Daley, Burge, & Davila; 2001), early maladaptive schemata related to personality disorders (c.f. Dreessen, Arntz, Hendriks, Keune, & van den Hout, 1999; Young, 1994), and schemata used in communication between family members (c.f. Fitzpatrick & Ritchie, 1994). The role of schemata in interpersonal interactions is explored in the net section.

The Role of Schemata in Interpersonal Interactions

Another line of research has explored schemas within the context of interpersonal interactions. While developing the Interpersonal Schema Questionnaire (ISQ), Hill and Safran (1994) explored participants' expectations of self-other interactions as a function of interpersonal schemas. Hill and Safran (1994) found respondents with higher levels of depression anticipated less amicable interactions with others, as opposed to respondents with lower levels of depressive symptoms. Hill and Safran (1994) also found respondents with higher levels of depression anticipated submissive reactions when acting in a servile manner and controlling reactions from others when acting in a controlling manner. Overall, these findings suggest depressed individuals' negative interpersonal schemata play a role in anticipating negative social interactions, thus eliciting rejecting interpersonal relationships.

In a similar vein, the therapist-client relationship is an interpersonal interaction that may be explored from a schema-theory perspective. As is true for other interpersonal interactions between two individuals, therapists' schemas guide interpretation and organization of incoming stimuli presented by the client. Applying this logic to the therapy relationship, affect, behavior, and content presented in therapy are filtered through the therapist's schemata and made sense of via the therapist's core beliefs and attitudes. Several interpretations of client behavior may occur as a result of schema activation within the context of therapy. Specifically, client issues may impinge on therapists' schemas and influence therapists' affective arousal, behavior, and thought processes in therapy. Similarity

between therapists' and clients' schemata may play a role in this process. The following section explores affective, behavioral, and cognitive reactions of therapists to client issues from a schema theory perspective.

Countertransferential Behaviors and Feelings: A Schema-Theory Perspective

Several studies (c.f. Hayes & Erkis, 2000; Hilliard, Henry, & Strupp, 2000) have explored the effects of therapists' attitudes or early parental relationships on aspects of the therapeutic process. Yet no known studies have explored these factors from a schema-theory perspective and how schema activation may predict countertransferential reactions of therapists.

Rumelhart (1984) stated "Schemata are employed in the process of interpreting sensory data, in retrieving information from memory, in organizing actions, in the determining goals and subgoals, in the allocation of resources and generally in guiding the flow of processing in the system" (p.162). Given that schemata organize interpretations of events and stimuli, they are central to resulting actions and behavior. In the same respects, therapists' schemata are central to interpretations made in therapy, which in turn guide therapist behavior. These interpretations and behavior are guided by personal constructs or schemata; therefore, therapists may display countertransferential behaviors or "…action(s) a counselor takes based on his or her conflict" (Robbins & Jolkovski, 1987, p.276) as a function of these personal constructs. Countertransferential behaviors and implications of these behaviors will be explored in a later section.

Therapists' affective responses may also be influenced as a result of these interpretations. Certain schemata guide therapists' interpretations in therapy, and in turn influence therapists' emotional responses. Personal constructs or schemata guide this process, therefore the therapist may display countertransferential feelings or "complex feelings and thoughts a counselor has in response to a client" (Robbins & Jolkovski, 1987, p.276) as a function of these personal constructs. Countertransferential feelings and implications of these feelings will be explored in a later section.

Interpretations made by therapists may also influence memory for client material presented in the therapy session. Rumelhart suggests interpretation and perception are central to memory. In describing the role of schemata in memory, Rumelhart (1984) states:

> First, they are the mechanisms whereby initial interpretations are formed and, as such, they determine the form of the memorial fragments. Second, schemata are used to re-interpret the stored data in order to reconstruct the original interpretation. There is ample evidence for both of these roles. The first point suggests that we remember our interpretations of an event rather than the event itself. (p.178)

This suggests memories are formed on the basis of initial interpretation, and schemata are used to organize and retrieve these memories at a later time. Therefore, personal constructs or schemata may influence the way these memories are initially stored and repeatedly retrieved in the future. Likewise, therapists' schemata might play some role in how initial client information is stored in memory, and may guide how client information is retrieved during one session or across several sessions.

Rumelhart (1984) goes on to discuss the importance of time lapses between storage and retrieval, and how reconstructing fragments of memory with self-schemas may lead to distortion of initially stored information. Rumelhart states:

> [T]he longer between presentation and recall the fewer memorable fragments are available and the more the subjects must rely on their generic knowledge of what situations like those for which they have memorial fragments are like-that is, their schemata. The less consistent their original information from the typical, the more room (and need) for distortion. (p.179)

Based on this assumption, therapists may be using generic knowledge structures or schemata to reconstruct fragments of information during time lapses in one therapy session or over several sessions. In efforts to reconstruct memories concerning clients, therapists may distort information in a manner consistent with their generic knowledge structures or schemata. For example, therapists might over or under-recall issues or details presented by clients possessing similar issues. Therapists' exploration and insight into their own schemas may prevent such distortions from impacting the course of therapy. The next section discusses the importance of therapists' examination of their own self-schemas, and how this process may enhance therapists' understanding of therapy processes.

Exploring Therapists' Schemas in Schema-Focused Cognitive Therapy

Schema theory suggests schemata may play a significant role in therapists' behavioral responses, affective responses, and cognitive processes in therapy, and schema theorists would encourage therapists to examine their own schemas vis a vis clients' schemas (Young, 1990, 1999). For example, in describing his Schema-Focused Cognitive Therapy for personality disorders (SFCT) Young (1999) suggests therapists examine possible influences of their own schemas in guiding a client through the assessment and change phases of SFCT. Neglecting to examine

possible influences of one's own schemata on the assessment and treatment of a client's schemata may considerably impede these latter processes.

Young also emphasizes the importance of examining therapists' schemata in individual supervision. Greenwald and Young (1998) explore supervision of Schema-Focused Cognitive Therapy and suggest supervisees examine their own early maladaptive schemata to improve both supervisory and therapy relationships. The authors state:

> Whenever possible, we urge supervisees to share their schemas and coping styles with supervisors, in case these become activated and create problems in therapy. This sometimes involves the supervisee filling out and sharing the results of the schema inventories, and doing one or two childhood imagery exercises with the supervisor. (p.115)

Greenwald and Young (1998) suggest several steps to follow in conducting psychotherapy supervision from a schema-focused perspective, one of which focuses on improving the relationship between the supervisee and client. The authors suggest supervisors explore the therapeutic relationship by focusing on the supervisee's schemas:

> B]egin by asking the supervisee to describe the therapist's and patient's feelings about each other. The supervisor then helps the supervisee to determine whether either the therapist's or the patient's schemas are being triggered in the session. A knowledge of the therapist's schemas is essential at this point to fully understand the interaction…. If the therapist's schemas have been activated, he is being helped to identify the relevant schemas, see how they are leading to a distorted perception of the patient, and then correct maladaptive interactions with the patient. (p.117)

Greenwald and Young (1998) suggest knowledge of a therapist's schemas is crucial in understanding dynamics between therapist and client and in maintaining

an accurate conceptualization of the client. The importance of examining therapists' schemata is not confined to SFCT. Another area of literature that supports this notion is research on characteristics of master therapists and personal therapy for therapists. Macran, Stiles, and Smith (1999) conducted an in depth qualitative analysis of interviews conducted with seven active therapists about their personal therapy and its influences on their work. In describing several benefits discovered by therapists seeking their own personal therapy, the authors state "…a therapist who has come to terms with his or her anxieties, resentments, and other personal problems is presumably able to work more effectively" and that "T]hey translated their learning about their own feelings and problems into an ability to distinguish their own feelings from their clients' feelings" (p.429). For these reasons, gaining insight into one's own self-schemata may influence the strength of the therapy relationship and treatment outcome. The next section describes studies of highly effective, peer-nominated therapists, and highlights the importance of therapists gaining insight into their own schemata.

Importance of Schema Self-Exploration in Therapists

Jennings and Skovholt (1999) conducted qualitative interviews with ten accomplished therapists selected by peer psychotherapists, and identified cognitive, emotional, and relational attributes that best captured therapist expertise. The authors point out that student therapists or novice therapists have traditionally been used to research effectual therapist variables, and that this study explored therapist characteristics in highly respected and experienced therapists. Ten master therapists were nominated by colleagues to participate in a semi-structured interview

comprised of 16 open-ended questions. Jennings and Skovholt (1999) identified three primary domains of characteristics (cognitive, emotional, relational), with each category consisting of three smaller subcategories. One area, the emotional domain, supports the notion that effective therapists gain insight into their own schemata and how their schemata may influence their work. In describing three subcategories of the emotional domain, the authors report "Master therapists appear to have emotional receptivity defined as being self-aware, reflective, non-defensive, and open to feedback" and that "Master therapists are aware of how their emotional health affects the quality of their work" (p.7). These results argue for the importance of therapists to explore their own schemata, and develop an awareness of how their personal knowledge structures guide their affective, behavioral, and cognitive responses in therapy.

In exploring countertransference from a schema theory perspective, it is helpful to identify specific kinds of schemata that may play a role in therapists' countertransferential responses. As mentioned previously, Young (1990, 1994, 1999) created Schema-Focused Cognitive Therapy and emphasized the importance of therapists' schemas in therapy and supervision. Young identifies 18 early maladaptive schemas (EMS) or "core themes" central to SFCT and has used this framework to explore EMS in personality disorders, romantic relationships, and clinical supervision. No known empirical research has explored schemata in therapists; and no known research has assessed the role of Young's 18 EMS in therapists' countertransferential responses. The next section provides a brief overview of Young's SFCT and his 18 early maladaptive schemata.

A SCHEMA-FOCUSED TREATMENT APPROACH

Young's Schema-Focused Cognitive Therapy (SFCT)

Negative involuntary thoughts, irrational beliefs, and assumptions have traditionally formed the framework for cognitive therapy. However, Young's Schema-Focused Cognitive Therapy (SFCT, 1990, 1994, 1999) is designed to emphasize Early Maladaptive Schemata (EMS). This approach is a unique derivative of Beck's cognitive therapy as treatment is based on the schema, a concept given lesser attention in Beck's previous treatment recommendations (Young, 1999). Bricker, Young, and Flanagan (1993) describe the EMS as:

> A] long-standing and pervasive theme that originates in childhood; defines the individual's behaviors, thoughts, feelings, and relationships with other people; and leads to maladaptive consequences. Core schemas are developed in early childhood as a result of ongoing noxious experiences, such as severe deprivation, rejection, abuse, instability, criticism, or abandonment. Early maladaptive schemas are therefore central to the person's sense of self and generate high levels of negative affect when activated. (p. 89)

Young and colleagues identify several properties of the early maladaptive schema (1999). The schema serves as a model for later experiences and develops throughout ongoing life experiences as the person bases his or her actions, thoughts, feelings, and interpersonal relationships on the schema (Young, 1999). The nature of the schema is dysfunctional and facilitates recurring psychological distress for the person; it is the product of ongoing dysfunctional experiences with attachment figures or peers in early life. The early maladaptive schema is a dysfunctional,

generalized theme that forms the individual's perceptions of self and interpersonal relationships over time. Schemas become comfortable and familiar to people, therefore the schema is durable and reluctant to change (Young, 1999). EMS are unconditional and absolute, therefore they are highly rigid. When events relevant to the EMS impinge on the individual, the schema will become activated. In many cases, activation of the schema results in intensified levels of affect accompanied by a variety of psychological problems (Young, 1999). Young suggests most individuals with characterological problems possess more than one EMS, and variations of each schema may be present. Young's early maladaptive schemata (1999) are described in the next section.

Young's Early Maladaptive Schemas

Young (1999) has identified eighteen early maladaptive schemata, which fall into five larger domains of functioning. Table 1 presents Young's 18 early maladaptive schemata and their corresponding domains. Young developed this list based on clinical experience with long-term therapy clients; however this list continues to grow and change. Young's original list of early maladaptive schemata was developed in 1990 and revised in 1994, 1995, and 1999 (See Appendix A for descriptions and domains of EMS).

Young also developed the Young Schema Questionnaire – Long Form (YSQ-L; Young, 1990), which is a 205-item self-report inventory designed to assess early maladaptive schemata. The YSQ-L assesses 16 early maladaptive schemata, and does not reflect the more recently derived 18 schemata described in this section.

The 16 early maladaptive schemata assessed by the YSQ-L will be presented in a later section.

Table 1

Young's Eighteen Early Maladaptive Schemata and Corresponding Domains

Domain	Early Maladaptive Schema
Disconnection and Rejection	Abandonment/Instability
	Mistrust/Abuse
	Emotional Deprivation
	Defectiveness/Shame
	Social Isolation/Alienation
Impaired Autonomy and Performance	Dependency/Incompetence
	Vulnerability to Harm or Illness
	Enmeshment/Undeveloped Self
	Failure
Impaired Limits	Entitlement/Grandiosity
	Insufficient Self-Control
Other-Directedness	Subjugation
	Self-Sacrifice,
	Approval-Seeking/Recognition-Seeking

Overvigilance and Inhibition	Negativity/Pessimism
	Emotional Inhibition
	UnrelentingStandards/
	Hypercriticalness
	Punitiveness

In addition to providing a unique approach to cognitive therapy for personality disorders, Young's schema-focused framework provides a strong theoretical basis from which to examine therapists' schemas and countertransferential reactions. As mentioned previously, Young suggests EMS "define the individual's behaviors, thoughts, feelings, and relationships with other people" and that "early maladaptive schemas are therefore central to the person's sense of self and generate high levels of negative affect when activated" (p.89). EMS serve as model(s) for later interpretations, and develop throughout ongoing life experiences as therapists base their actions, thoughts, feelings, and interpersonal relationships on these schemas (Young, 1994).

Young's Schema Processes

Young (1994) identifies three schema processes unique to the early maladaptive schema: schema maintenance, schema avoidance, and schema compensation (p.12). Schema maintenance refers to the individual's attempt to support or endorse the schema through dysfunctional thoughts or behaviors (e.g., a

person with an abandonment schema seeking relationships with unavailable partners). Schema avoidance involves the individual's efforts to escape activation of the EMS or the intense emotions accompanying the EMS in question (Young, 1994). This may be accomplished by adopting specific thoughts, actions, or emotions designed to evade the schema (e.g., a person with an emotional deprivation schema does not attend a social gathering to avoid feeling like an outsider, therefore perpetuating the schema). Schema compensation refers to the tendency of individuals to adopt certain thought patterns or behaviors in order to rectify or counteract the early maladaptive schema (Young, 1994). Often these thoughts or actions are contrary to what might be expected from the schema. To some degree this process can be adaptive, however schema compensation may backfire and bring the person back to the original or another equally distressing schema. An illustration of this process would be a person with a defectiveness schema becoming overly confident around her peers, causing her to be negatively evaluated and feeling as if she is incapable of winning the affection of others (Young, 1994).

For these reasons, schema-relevant events in therapy may affect the therapist, causing his/her schema(s) to become activated. This activation may influence countertransferential reactions, such as affective responses, verbal behavior, and cognitive processes in therapy. The next section examines empirical research on countertransference, with particular emphasis on affective, behavioral, and cognitive indices of countertransference.

COUNTERTRANSFERENCE

Definitions and Conceptualizations

The therapist/client relationship is central to psychotherapy, and there is considerable agreement that therapists' personality is an important factor in the therapy process. In his early writings, Freud described countertransference as "…the analyst's unconscious, neurotic reaction to the patient's transference" and cited it as "…one of the analyst's primary nemeses" (1910/1959a; as cited in Hayes, Gelso, Van Wagoner, Diemer, 1991, p. 139). Fromm-Reichman (1951; as cited in Cutler, 1958, p. 349) describes countertransference as "the process of transferring to and repeating early patterns of interpersonal relatedness with present day partners."

Since these classical definitions have been established, considerable debate has ensued surrounding what encompasses countertransference and whether countertransference is a hindrance to the therapeutic process (Friedman & Gelso, 2000). Traditional definitions of countertransference, such as those proposed by Freud, were thought by many contertransference theorists to be too narrow as they focused solely on responses out of therapists' awareness and in reaction to clients' transference onto the therapist (Hayes & Gelso, 2001). Thus a "totalistic view" was created (Kernberg, 1965), which conceptualized countertransference as all practical and impractical emotions and thoughts therapists experience in response to clients (Friedman & Gelso, 2000). More recent theorists have developed yet another definition of countertransference, as the totalistic view was thought to be ambiguous and overly encompassing (Friedman & Gelso, 2000; Hayes & Gelso, 2001). This new definition suggests countertransference refers to "therapists' reactions to clients that are based on therapists' unresolved conflicts" and that "…countertransference

may be conscious or unconscious and in response to transference or to other phenomena" (Hayes & Gelso, 2001, p.1042).

Countertransferential Feelings, Behaviors, and Triggers

Robbins and Jolkovski (1987) pointed out a common distinction made by more recent theorists surrounding countertransference, countertransference behavior verses countertransference feelings. The authors state "Countertransference behaviors refer to the action a counselor takes based on his or her conflict, whereas countertransference feelings refer to the complex feelings and thoughts a counselor has in response to a client" (p.276). Several countertransference theorists suggest countertransferential feelings are expectable and normal reactions of therapists, but that overt countertransference behaviors may predict poor treatment prognosis and be harmful to therapy (c.f. Hayes & Gelso, 2001).

Hayes and Gelso (2001) propose three types of countertransference triggers: client attributes, therapy content, and therapy process. Client attributes refer to physical or ethnic characteristics apparent in a client's physical appearance, with which therapists make a personal connection and experience a corresponding countertransferential reaction. For example, a therapist's countertransferential reaction to a Latina client may be modeled by that therapist's style of interaction with a Latina friend (Hayes & Gelso, 2001). Therapy content, which has been given the most attention in countertransference research, refers to client material associated with therapists' own intrapsychic conflicts. Countertransferential

reactions to therapy content may represent attempts by the therapist to shield him or herself from being harmed by the conflictual material. Triggers surrounding therapy process refer to countertransferential reactions to the dynamics existing between therapist and client during, between, and across sessions. For example, Hayes and Gelso (2001) suggest a client who exhibits dependency needs with the therapist throughout the therapy relationship may stimulate countertransferential reactions.

Gelso and Hayes (1998; as cited in Friedman & Gelso, 2000) propose a "…two person psychology, where transference is not viewed as a distortion but rather a client schema or template that becomes stimulated by; and enacted within, the client-therapist relationship." The authors go on to suggest that countertransference behavior "…may be viewed as enacting schemas related to missing or unfulfilled relationships in the therapists' past" (2000, p.1231).

Countertransference Management and Influences on Treatment

Another question spawning debate is the necessity for therapists' management and regulation of countertransferential reactions. Freud strongly advocated therapists seek analysis to effectively manage countertransference, and some theorists (e.g. Hayes, Gelso, VanWagoner, & Diemer, 1991) have explored qualities of therapists that facilitate effective regulation of countertransferential feelings. However, more recent thinking on countertransference suggests these reactions may be desirable and useful material for the therapist to use in treatment. Gelso and Carter (1994) point out that countertransference can provide valuable

information about the client, his/her prognosis, and a window into his/her interpersonal style.

More recently, distinctions have been made between therapeutic usefulness of countertransferential feelings verses countertransferential behaviors. Friedman and Gelso (2000) suggest that countertransferential feelings play an inevitable role in therapists' internal experience, and that these inner reactions are a harmless means of better understanding the clients' presentation in therapy. Friedman and Gelso (2000) go on to suggest that therapists' disregard of countertransferential feelings may facilitate countertransferential behaviors or actions taken by therapists in response to their own inner conflicts. Countertransferential behaviors, as opposed to countertransferential feelings, are thought to be harmful to therapy and therefore therapists are encouraged to acknowledge countertranferential feelings to prevent potentially harmful manifestation of countertransferential behaviors (Friedman & Gelso, 2000).

Another line of research has explored relationships between management of countertransference, client functioning, and client outcome. Lambert, Bergin, and Collins (1977) explored client progress as a function of therapists' negative countertransferential feelings, and suggested a causal relationship between therapists' negative feelings toward clients, therapists' attitudes toward clients, and clients' worsening during therapy. Lambert and colleagues (1977) also referred to studies that pointed to a positive relationship between therapists dealing poorly with anger and clients worsening during treatment. Reisner and Levinson (1984) suggested countertransferential feelings of hate can lead to misdiagnosis of more stigmatizing psychological disorders, such as borderline personality disorder. When

mismanaged and acted upon, feelings of attraction on the part of the therapist may lead to sexual relations that are injurious for both therapist and client.

More recent investigations of countertransference and treatment outcome are scarce. One line of research has explored the effects of countertransferential behaviors on "…distal-therapy outcomes" or therapeutic gains following termination of therapy (Hayes & Gelso, 2001, p.1049). Few studies have investigated positive associations between management of countertransference and successful treatment outcome. On the contrary, Hayes (1995) found no relationship between countertransferential behavior and treatment outcome, yet the author did find that in clients with poor therapy outcome, a negative relationship existed between treatment improvement and amount of countertransferential behaviors demonstrated during therapy. And in somewhat successful to successful cases, there was no relationship between countertransference behavior and treatment outcome (Hayes & Gelso, 2001). Other studies have explored the effects of countertransference management skills on treatment success, and suggest that analytical abilities, self-integration, and coping skills for anxiety predict better therapy outcomes (Hayes & Gelso, 2001). It appears that the relationship between countertransference management and therapy outcome is not as linear as once thought, and that several other factors, such as therapists' qualities, may mediate this relationship.

Challenges in Investigating Countertransference

Without question there are several interesting lines of research to pursue surrounding countertransference, but surprisingly, relatively few empirical studies

have examined these issues. There are several reasons for the paucity of research in this area. First, it has been difficult to examine feelings and conflicts of a population (e.g. therapists) that have knowledge and training in personality and psychopathology. Secondly, these variables are very difficult to operationally define. Most studies rely on retrospective reports of therapy sessions that attempt to assess months or years of therapy in a single assessment. Recent studies examining countertransference are using more creative and systematic means of measurement, such as videotaped therapy sessions and session-by-session monitoring of countertransferential feelings and behavior.

Another reason for the lack of successful research surrounding countertransference is that researchers have examined countertransference without taking therapists' individual intrapsychic conflicts and personalities into account (Hayes & Gelso, 2001). These studies (c.f. Yulis & Kiesler, 1968) neglect to assess how different types of clients interact with therapists' intrapsychic conflicts to produce countertransferential reactions unique to each therapist.

This section will examine countertransferential feelings and behaviors, specifically, affective, behavioral, and cognitive responses of therapists. Recent examinations of these variables will be discussed, along with the creation and operationalization of these measurement techniques.

Affective Responses in Countertransference

Therapists' possible affective responses to clients are virtually infinite, however the majority of research has focused on fear, anger and attraction. In a review of empirical literature examining countertransference feelings, Harris (1999)

points out that "boredom, envy, jealousy, frustration…" (p.365) and many other constructs would be useful additions to literature on countertransference feelings. Harris (1999) focuses on three main areas of investigation: research exploring frequency of therapists' emotions toward clients; studies examining the effects of these feelings on clients, therapists, and treatment; and studies examining therapist variables that influence either the frequency or effects of these feelings. Much of the research Harris reviews surveyed random membership from divisions of the American Psychological Association or used videotaped vignettes of actors portraying clients with presenting issues designed to elicit countertransferential reactions.

Following examination of the empirical literature, Harris (1999) suggested "…psychotherapists find their work to be emotionally evocative and impacting. Fear, anger, and attraction toward clients are common experiences for psychotherapists. Many psychotherapists reported that they are confused, ashamed, and stressed by the experiences of these feelings" (p. 372). Respondents also indicated these feelings directly and negatively influence treatment, elicit actions that are injurious to therapy, and that they did not feel their training sufficiently prepared them to deal effectively with countertransferential feelings (Harris, 1999).

Hayes and Gelso (2001) encouraged researchers to consider a broader range of emotional responses in exploring these phenomena. One study which conducted post-therapy interviews with eight therapists (Hayes, McCracken, McClanahan, Hill, Harp, & Carozzoni, 1998) indicated that therapists experienced various emotions, including but not limited to; anger, boredom, sadness, nurturance, and inadequacy due to countertransference. Hayes and Gelso (2001) went on to suggest

that these emotional reactions are indicative of therapists' intrapsychic conflicts, and that therapists should explore the sources of these responses to better understand countertransference behaviors.

Anxiety as a Countertransferential Reaction

In a study examining therapist variables that predict effective management of countertransferential feelings, Hayes, Gelso, Van Wagoner, and Diemer (1991) suggested anxiety management is central to regulation of countertransference in therapy. Recent empirical examinations of countertransference suggest anxiety in therapists is indicative of countertransference and a negative relationship exists between therapists' effective management of his/her anxiety and the frequency of countertranference behaviors.

Several more recent studies have examined therapists' countertransferential reactions toward gay/lesbian clients and HIV positive clients as a function of homophobic feelings and death anxiety (c.f., Gelso, Fassinger, Gomez, & Latts, 1995; Hayes & Gelso, 1993).

In a study examining three different types of countertransferential reactions, Hayes and Gelso (1993) explored male therapists' state anxiety in response to videotaped vignettes of either gay or heterosexual and either HIV negative or HIV positive clients as a function of therapists' self-reported homophobia and death anxiety. Following completion of homophobia and death anxiety self-report measures, 34 therapists viewed and responded to one of eight randomly assigned videotapes. Therapists were asked to assume six previous sessions had occurred

between themselves and the client. During the videotaped session, therapists provided verbal responses to the client at predetermined points in the session. Following the videotape, therapists completed a state anxiety measure and cognitive recall index. Hayes and Gelso (1993) selected state anxiety to measure therapists' affective arousal as anxiety has been negatively correlated with perceptions of therapy performance (Bandura, 1956), perceptions of therapists' empathy (Bergin & Jasper, 1969), and outcome of therapy (Kelly, Hall, & Miller, 1989). The State Anxiety scale of the State-Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, & Lushene, 1970) was administered immediately following the videotape and therapists were asked to complete the measure in reference to what they were feeling while watching the videotape. Overall, therapists experienced greater discomfort in response to HIV positive clients than HIV negative clients, and therapist homophobia was more strongly associated with discomfort with gay clients as opposed to discomfort with heterosexual clients. State anxiety was the only dependent measure that significantly predicted therapists' discomfort.

Sharkin and Gelso (1993) explored therapist trainees' discomfort with and anger toward angry clients, as a function of proneness to and discomfort with anger. Thirty-eight counselor trainees completed two self-report measures of anger-proneness and anger discomfort. Counselor trainees were randomly assigned to view one of two videotapes depicting a female client and were asked to presume they had seen the client for previous sessions. The client expressed anger toward the counselor regarding homework assignments, her overall experience in therapy, and beginning sessions on time. After each trainee viewed his/her assigned videotape,

he/she completed shortened versions of the State-Trait Anxiety Inventory (STAI-S; Spielberger, Gorsuch, & Lushene, 1970) and the State-Anger Scale (STAS-S; Spielberger, Jacobs, Russell, & Crane, 1983; as cited in Sharkin & Gelso, 1993). Participants were told to report their feelings in reference to the client they had just viewed on the tape. A positive relationship was detected between discomfort with and anger toward the client and therapists' proneness to anger. High levels of proneness to anger were associated with high levels of discomfort with and anger towards clients depicted in the videotapes, suggesting that uneasiness with one's own anger may lead to distress and anxiety when being the focus of another person's anger. Sharkin and Gelso concluded "…when client material (anger in this case) touches on counselor feelings and issues that are unacceptable to the counselor (the tendency to be angry in conjunction with discomfort with one's own anger), the result will be anxiety in the counselor, expressed as discomfort with the angry client" (p.486).

In a later study, Gelso, Fassinger, Gomez, and Latts (1995) explored therapists' countertransferential reactions to lesbian clients as a function of therapists' gender, degree of homophobia, and ability to manage countertransference. An altered version of the Countertransference Factors Inventory (CFI; Hayes, Gelso, VanWagoner, & Diemer, 1991) was used to assess therapists' ability to control countertransference and was completed by participants' clinical supervisors. Sixty-seven therapists completed self-report measures of homophobia and were randomly assigned to watch a video tape of either a lesbian or heterosexual client discussing sexual difficulties in a current romantic relationship. In line with Hayes and Gelso (1993), the authors explored therapists' cognitive,

affective and behavioral responses to the videotapes. Therapists' state anxiety was measured immediately following each video using the State Anxiety scale of the State-Trait Anxiety Inventory (STAI-S; Spielberger, Gorsuch, & Lushene, 1970). Unlike Hayes and Gelso (1993), therapists' affective response to each condition did not yield significant results.

Behavioral Responses in Countertransference: Approach verses Avoidance

Surprisingly little empirical research has focused on countertransferential behaviors and how such behaviors impact the course of therapy. One method of exploring countertransferential behaviors has been through examining therapists' approach or avoidance responses to clients in session. This view is based on the assumption that therapy discourse may be guided by operant conditioning or that therapists' approach responses represent positive reinforcement and avoidance responses represent negative reinforcement (Varble, 1968). Approach-avoidance responses may be thought of as verbal behaviors that encourage or discourage discourse in therapy, and these responses may be detected in a range of therapists' behaviors. It has also been argued that encouraging or discouraging exploration of certain issues via therapists' approach or avoidance responses predicts therapy outcome (c.f. Varble, 1968).

Approach-avoidance responses of therapists have received considerable attention in empirical literature on countertransference. Several studies have explored therapists' approach-avoidance responses in working with expressions of hostility (Bandura, Lipsher, & Miller, 1960), lesbian and gay clients (Hayes &

Gelso, 1993; Gelso, et al., 1995), and clients with low levels of intellectual functioning (Campbell & Browning, 1975).

Bandura, Lipsher, and Miller (1960) originated this approach in response to an earlier study (see Bandura, 1956) that suggested a negative relationship between therapists' self-reported anxiety and ratings of their effectiveness as a therapist. Bandura, Lipsher, and Miller (1960) explored this relationship further by focusing on specific ways the quality of therapists' work may be influenced by anxiety. The authors based this study on the notion that for progress to take place, the client's feelings must be permitted to occur in session. However, if certain emotions are anxiety-producing for the therapist, the client may not be encouraged to freely explore these feelings in therapy. As a result, the client's expression of anxiety-producing material brings about therapists' avoidance of issues that may be therapeutic for the client to examine.

In a study examining this relationship in reference to hostility, Bandura and colleagues (1960) predicted that therapists with high anxiety surrounding expressions of hostility would respond to client expressions of hostility with avoidant responses and be less likely to respond with approach responses than therapists with low anxiety surrounding expression of hostility. It was also predicted that avoidance responses would act as negative reinforcers, thereby discouraging exploration of the anxiety-producing information; and approach responses would represent positive reinforcers and elicit further exploration of anxiety-producing feelings from the client. Bandura and colleagues (1960) also hypothesized that following therapists' avoidance responses to clients' expression of hostility, clients

would shift the target of their hostility, and this change would occur more often than when therapists provided approach responses.

To test this hypothesis, the authors conducted a response by response analysis of therapists' replies to hostility in 110 interviews taken from parents seeking therapy at a parent-child community-counseling center. Ratings assigned by supervising staff psychologists whom had professional and social contact with each of the therapists were gathered as measurements of therapists' personality. Three staff members rated each therapist's degree of hostility anxiety and dependency behavior on a 5-point scale. The interviews were coded in scoring units or interaction sequences consisting of a client statement, therapist response, and a second client response. Expressions of "dislike, resentment, anger, antagonism, opposition or of critical attitudes" (p.2) were defined as hostility. The authors also coded the object of the client's hostility. Approach responses are those that invite further hostile expression from the client and may be described as approval, exploration, instigation, reflection, and labeling. Avoidance responses suppress the client's hostile expression and may be illustrated through silence, changing topics, disapproval, ignoring, or mislabeling. Impertinent or unusable responses were coded as unclassified responses (Bandura et. al., 1960).

Results suggest therapists who supported clients' expressions of hostility were more likely to display hostility directly themselves and to have less desire for others' approval, and more so than therapists who did not display direct hostility and have a high desire for others' approval. The authors also suggested that when hostility is directed at them, therapists display greater avoidance responses, as opposed to when hostility is directed toward other targets. Finally, when therapists

responded to hostility with avoidance responses as opposed to approach responses, clients were more likely to shift from expressions of hostility or change the target of their hostility (Bandura et al., 1960).

In a related study, Schuldt (1966) used therapists' approach-avoidance responses to explore dependency in the therapeutic relationship. In contrast to earlier studies that explored these factors in light of beginning stages of therapy, Schuldt explored dependency and approach-avoidance responses during the therapy relationship over time. Two raters coded expressions of dependency and approach-avoidance responses in 80 taped therapy sessions gathered from a university-counseling center. The results of this study suggest approach responses promote further dependency from the client and avoidance responses result in a discontinuation of dependency from clients. Contrary to Schuldt's hypothesis that approach responses would decrease over the course of therapy, results indicated that throughout stages of therapy therapists provide approach statements at a constant rate. The results also indicated that therapists provide more approach responses following dependency aimed at them as opposed to dependency aimed at other objects in the client's world. Schuldt also explored approach responses in beginning stages of therapy as a function of therapists' level of experience; however, the data did not support this relationship. Finally, Schuldt suggested clients initiate considerably more dependency responses in beginning stages of therapy rather than during final stages of therapy, which provides empirical support for the notion that dependency on the therapist decreases over the course of therapy in many cases.

Varble (1968) conducted a similar investigation that supported results of the study conducted by Bandura and colleagues (1960); yet unlike Bandura's previous

studies, Varble explored this relationship using a longitudinal approach and examines therapists' verbal behaviors as a function of professional experience. Eighty interviews gathered from different stages of psychotherapy were taken from 16 clients seen at a university-counseling center. Two raters coded client and therapists' expressions of hostility and approach-avoidance responses. Results suggest approach responses invite more expressions of hostility than avoidance responses in all phases of therapy, a finding which replicates those of Bandura (1960) but is unique in that Varble's findings suggest this dynamic exists over the entire course of therapy. Another finding unique to Varble's work is in regards to approach-avoidance responses as a function of therapist expertise. Varble's findings suggest less experienced therapists approach expressions of hostility directed at themselves, whereas more experienced therapists approach hostility when directed at objects other than themselves. This result suggests professional expertise may predict therapists' choice of verbal behavior, and different kinds of emotional expression may differentially predict verbal responses from therapists.

Recent Investigations of Approach-Avoidance Countertransferential Behavior

More recent empirical investigations have used approach-avoidance responses as a measurement of countertransference behavior. For example, therapists' approach-avoidance responses have been used to examine therapists' countertransferential behaviors toward lesbian, gay, and HIV positive clients (see Hayes & Gelso, 1993; Gelso, et al., 1995). In Hayes and Gelso (1993), the authors examined approach-avoidance responses of 34 male therapists as a function of

clients' sexual orientation, HIV status, and therapists' level of homophobia and death anxiety. The authors used coding procedures based on those used by Bandura, Lipsher, and Miller (1960) to rate male therapists' responses to videotaped clients within one of four experimental conditions: gay and HIV positive, gay and HIV negative, heterosexual and HIV positive, or heterosexual and HIV negative. Three 2nd-year doctoral students in counseling psychology calculated a ratio of the number of avoidance responses to the sum of approach and avoidance responses. As expected, male therapists' level of homophobia and avoidance responses revealed a stronger association in the gay client condition (r = .78) as opposed to the heterosexual client condition (r = -. 23). This finding emphasizes the importance of counselors' being aware of homophobic feelings toward gay and/or HIV positive clients, and how such countertransferential feelings and behaviors may impact the course of therapy.

Gelso, Fassinger, Gomez, and Latts (1995) explored therapists' approach-avoidance responses to lesbian or heterosexual females as a function of therapists' homophobia and ability to manage countertransference. Sixty-seven male and female therapists viewed videotaped vignettes of lesbian or heterosexual clients discussing sexual concerns in a current romantic relationship. On arrival therapists were asked to complete a self-report homophobia scale and each therapist's supervisor was mailed a questionnaire designed to assess the participant's ability to manage countertransference. Following completion of the measures, therapists viewed his/her assigned vignette. Therapists' approach-avoidance responses were recorded at predetermined points in the vignette. Four doctoral students in counseling psychology categorized therapists' responses as approach, avoidance, or

other. In line with Hayes and Gelso (1993), each therapist was assigned an avoidance score representing each therapist's percentage of avoidant responses. As hypothesized, therapists with high levels of homophobia in the lesbian condition provided more avoidant responses ($r = .35$, $p < .05$). That is, homophobia and frequency of avoidant responses were positively correlated for therapists viewing lesbian clients. On the other hand, homophobia and avoidant responses were not correlated for therapists in the heterosexual condition ($r = .03$, $p > .05$).

Taken together with significant findings surrounding avoidant responses toward gay and HIV positive clients in Hayes and Gelso (1993), these results emphasize the importance of therapists' feelings and attitudes in predicting behavioral responses in therapy. Furthermore, studies have demonstrated a strong association between avoidant responses and negative treatment outcome. For these reasons, therapists' approach-avoidance responses to a variety of personality types, presenting issues, and client backgrounds is an area of research deserving further attention. Therapists' level of anxiety and/or discomfort surrounding specific issues may differentially predict verbal responses in therapy, and therapists may respond to clients' presenting issues in a manner which encourages or discourages exploration of a specific topic. If clients are not given permission to freely explore these issues in therapy, clients' experience in therapy may be negatively influenced.

While many prior studies of countertransference behavior have explored avoidant or withdraw-oriented behaviors of therapists in response to conflictual material, more recent investigations have found that therapist over-involvement may also represent countertranferential behavior (Hayes & Gelso, 2001). Therapists' countertransferential responses may also take the form of therapists' over-

identification with the client, which may elicit over-involvement, excessive support, or excessive talking from the therapist (Friedman & Gelso, 2000). Hayes and Gelso (2001) suggest therapist gender may predict avoidance and over-involvement countertransferential reactions. For example, the authors' previous studies (c.f., Hayes & Gelso; 1991, 1993) suggest male therapists' countertransferential behavior takes the form of withdrawal or avoidant behavior, whereas preliminary studies (Hayes, et al., 1998) suggest female therapists' countertransferential behavior might take the form of over-engagement with clients.

Cognitive Responses in Countertransference: Recall for Events in Therapy

Perceptual error or cognitive distortion toward clients or client material is intricately tied to countertransference, and therapists' distorted perceptions often manifest countertransferential behaviors (Hayes & Gelso, 2001). One widely examined index is cognitive recall of words or events presented in the therapy session. In his classic article on countertransference, Cutler (1958) explored the "strong need satisfying hypotheses" which may be "…confirmed on the basis of minimal appropriate information from the environment" (p.350). Cutler draws a parallel to a concept Nunberg describes as "seizing upon some detail in the environment in order to project inner wishes upon the current reality" (Cutler, 1958, p.350). Therefore, transference and countertransference may be thought of instances in which a person's needs or wishes sway perception.

Taking this idea further, Culter suggests specific relationships may be assumed between the therapist's intrapsychic conflicts and his/her capacity to form unbiased perceptions of the therapeutic relationship. Cutler (1958) states:

> When no conflict is present, and no defensive countertransference reactions are necessary, he should perceive and report this behavior with relative objectivity. On the other hand, when the stimulus situation is such that material impinges upon the therapist's needs and conflicts, we should find systematic tendencies to omit, distort, or over emphasize certain aspects of the behavior. (p.350)

Given these conditions, the therapist's needs color his/her interpretations of behavior and influence treatment outcome. Ideally, the therapist develops awareness of this process via supervision and/or consultation. Cutler (1958) points out, however, that therapists' in-the-moment interactions with client cannot be closely managed, and may lead to misperceptions that influence treatment outcome. In efforts to manage anxiety-provoking information in therapy, distortion of behavior acts a defense for the therapist. Under- or over-recall of information, distortions, or exaggerations of information act as a protective mechanism for the therapist. Cutler (1958) points out that these defensive operations force the therapist to become distracted from the psychotherapy, redirecting energy and focus toward his/her own conflicts. As a result, the therapist is not fully engaged in therapy and neglects the client's need to examine the conflictual material. Cutler (1958) also suggests that the occurrence in which clients discussed material related to therapists' intrapsychic conflicts was often over and under-estimated by therapists.

Brown (2000) illustrates this process while emphasizing the role of cultural heritage in countertransference, and suggests therapists and clients represent symbolic social constructs that influence memory of events in therapy. For example,

Brown described her difficulty remembering material from sessions with a Jewish incest survivor, and suggests her own Jewish heritage led her to be incredulous of incest in a Jewish family and distort recall for information about this client.

Cutler's examination of these concepts has become the basis of current empirical research on countertransference feelings and behavior. His classic study focused on two hypotheses. First, Cutler proposed therapists would over- or under-emphasize client information which conflicted with his/her needs as opposed to information which did not conflict with his/her own needs. Secondly, Cutler hypothesized that when behavior exhibited by the client resembles behavior of the therapist and is believed to be conflictual for the therapist, the therapist's responses to this behavior would be less therapeutic than responses to client behavior that is not conflictual for the therapist (Cutler, 1958).

To test these hypotheses, Cutler selected ten therapists to give self-ratings on 16 personality dimensions taken from "The Circle," a system developed for categorizing aspects of interpersonal relationships. In addition to therapists providing self-ratings on these dimensions, ratings were gathered from nine other individuals who had close relationships with the therapist he/she rated. Both self-ratings and judges' ratings were gathered on the following personality dimensions: dominating, boastful, rejecting, punitive, critical, complaining suspicious, apologetic, submissive, respectful, dependent, agreeable, affiliative, supportive, generous, and advising. Therapists and judges rated these characteristics on a 19-point scale, ranging from "most characteristic to least characteristic."

Cutler identified conflict areas for each therapist by measuring discrepancies between the therapists' and judges' ratings. This approach was used as judges' ratings represent actual behavior in the presence of the judge, however because therapists may possess a less realistic perception of his/her behavior, therapists' ratings may be over- or under-estimates of a specific characteristic. Cutler identified two categories of conflict, plus-conflict and minus-conflict. Plus-conflict refers to traits on which the therapist provided exaggerated scores in contrast to judges' scores, and minus-conflict refers to traits on which the therapist gave himself lower scores than scores provided by the judges. Conflict-free traits were those in which judges' scores closely fit the therapists' self-assigned scores (Cutler, 1958).

Two therapists were chosen from this group to participate in the remainder of the study. Both therapists tape-recorded individual therapy sessions and wrote specific accounts of events in each session The therapy sessions and written accounts were transcribed with special attention to pauses, speech rate, emotional expression, and content of responses (Cutler, 1958). Each therapist's actual individual therapy sessions were coded using the 16 interpersonal behavior categories from the Circle. Both the therapists' and clients' expressions of the 16 dimensions were totaled across all the interviews of each therapist. This measure was known as the objective picture as it assessed behaviors of the therapist and client during the actual interviews. The same analysis was completed on the therapists' reports following each therapy session. This measure was labeled perception as it represents the therapists' report of his and the client's behaviors (Cutler, 1958).

To examine the hypothesis that therapists would provide less effective responses to conflictual information, judges rated therapists' responses as either "task-oriented" or "ego-oriented." Task-oriented behavior invites examination of an issue which would be therapeutic for the client; however, ego-oriented behavior serves the intrapsychic conflicts of the therapist and neglects responses which may be therapeutic for the client. Cutler suggests persistent use of ego-oriented responses negatively influences treatment outcome and impedes the client's improvement. Cutler also asserts that ego-oriented responses are attempts for the therapist to defend against anxiety-provoking information, and that ego-oriented responses will immediately follow client statements consisting of material conflictual for the therapist (Cutler, 1958).

Culter's results suggest therapists' reports of their own and clients' behaviors in therapy are distorted and inaccurate. In 25 out 27 cases, therapists reported more behaviors than actually took place. Cutler draws a parallel between these mechanisms and classic defensive responses. Specifically, he parallels under-reporting one's characteristics or minus conflict with denial and repression, and overestimating one's characteristics or plus conflict with intellectualization or isolation (Cutler, 1958).

Results also suggest an association between conflicts presented in client statements which are conflictual for the therapist and ineffective therapist responses immediately following these statements (Cutler, 1958). This supports the notion that client behavior which is conflictual for the therapist influences his/her efficacy with that client. Furthermore, associations were detected between task and ego-oriented responses and therapists' level of experience and self-insight gained from personal

psychotherapy (Cutler, 1958). Based on the premise that a greater number of task-oriented than ego-oriented behaviors represents higher quality therapy, experience and self-insight may enable therapists to effectively manage client information conflictual for them (Cutler, 1958).

Recent Investigations of Cognitive Recall as an Index of Countertransference

Several studies have explored countertransferential behaviors based on Cutler's work. A common approach to examining under or over-recall of client material is to assess cognitive recall of words or details thought to influence countertransferential feelings in therapists. Some of these studies examine cognitive recall of material relevant to certain content areas or self-reported attitudes from therapists. Other studies have examined memory processes in counseling which suggest positive associations exist between correctness of therapists' recall and ratings of therapists' likability (Gardner, White, Packard, & Wampold, 1988) and that memory processes of both therapist and client play a central role in the therapy process (Kraft, Glover, Dixon, Claiborn, & Ronning, 1985). In contrast to behavioral and affective responses of therapists, cognitive recall appears to be less subject to social desirability influences as therapists may more easily monitor self-report measures or behavioral responses than recall behavior (Gelso, et al., 1995).

Research examining countertransference reactions to lesbian, gay, and HIV positive clients has used the cognitive recall index as a means of measuring this type of countertransferential behavior. For example, in Hayes and Gelso (1993), the authors examined cognitive recall of words related to death and sexuality in 34 male

therapists as a function of clients' sexual orientation, HIV status, and therapists' level of homophobia and death anxiety. The authors proposed that conflict associated with death and sexuality would predict degree of error with which therapists recall words from sessions exploring these content areas. Therapists viewed videotaped clients within one of four conditions, either gay or heterosexual and either HIV positive or HIV negative. Following the manipulation, each therapist completed the measure of cognitive recall. A cognitive distortion index was derived for each therapist. The index was calculated using "percentages in which the numerator was the absolute difference between the actual and estimated number of times words related to death (e.g. "die") and sexuality (e.g. "gay") were mentioned by the client, and the denominator was the number of times words were actually mentioned by the client" (p. 88-89). Words related to sex and death, mentioned by clients in the stimulus tapes, were coded by the primary investigator. As expected, HIV positive clients elicited more discomfort from therapists than HIV negative clients, however cognitive recall for death and sex-related words did not contribute to this finding (Hayes & Gelso, 1993).

Gelso, Fassinger, Gomez, and Latts (1995) explored therapists' cognitive recall of sexual words in response to lesbian or heterosexual females as a function of homophobia and ability to manage countertransference. Sixty-seven male and female therapists viewed videotaped vignettes of lesbian or heterosexual clients discussing sexual concerns in a current romantic relationship. On arrival therapists were asked to complete a self-report homophobia scale and each therapist's supervisor was mailed a questionnaire designed to assess the participant's ability to manage countertransference. In line with Hayes and Gelso (1993), therapists were

asked to predict the frequency with which sexual words were mentioned by the client he/she had viewed. The authors and a team of undergraduate research assistants agreed on the number of sexual words presented in each videotaped condition. Sixteen different sexual words were presented in the vignettes and a total of 38 or 39 sexual words were counted in each condition. Examples of sexual words are sex, erotic, sex maniac, and made love. Each therapist was assigned a recall score representing a deviation from the average total number of sexual words used in each videotaped condition. Higher scores indicate greater recall error. In contrast to Hayes & Gelso (1993), Gelso and colleagues (1995) observed a significant effect for cognitive recall. Specifically, in the lesbian condition, female therapists demonstrated more errors recalling sexual words than did male therapists, whereas in the heterosexual female condition, male and female therapists had comparable error rates.

New Directions in Cognitive Manifestations of Countertransference

More recent investigations of cognitive manifestations of countertransference are examining other types of responses; such as therapists' attitudes and decision-making surrounding treatment and therapists' ability to reflect mindfully on client material (see Hayes & Gelso, 2001). For example, Hayes and Erkis (2000) explored various cognitive reactions of therapists in response to clients with HIV. In contrast to previous studies that measured transference in terms of therapists' over or under-recall of conflictual material, this study explored therapists' empathy, attributions surrounding client responsibility, therapists' willingness to

provide services with HIV positive clients, and therapists' perception of clients' overall functioning. Four hundred and twenty-five randomly selected psychologists read a vignette illustrating either a gay or heterosexual male client, who had contracted HIV via sexual contact, blood transfusion, intravenous drug use, or cause was non-specified. Participants completed a self-report measure of homophobia, and measures assessing empathy, attributions of responsibility, assessment of functioning, and willingness to work with the client depicted in the vignette. Results indicate that therapist homophobia and origin of HIV infection were associated with therapists' perceptions of clients' responsibility in causing his problems (Hayes & Erkis, 2000). In addition, the manner in which HIV was contracted, the client's sexual orientation, and therapists' level of homophobia predicted therapist empathy, attributions surrounding the client's responsibility for solving his problems, assessment of the client's overall functioning, and willingness of therapists to provide services to the client (Hayes & Erkis, 2000). It appears therapists may exhibit a variety of cognitive reactions to client attributes, and that explorations of cognitive countertransferential reactions need not be limited to distortion of client material.

Therapists' countertransferential reactions have been explored in relation to homophobia, client sexual orientation, HIV status, hostility, anger, and dependency. This area of literature has yielded some inconsistent results surrounding affective, behavioral, and cognitive responses of therapists. Nevertheless it is reasonable to expect that numerous client variables evoke countertransferential feelings and behaviors from therapists. It is also possible that therapist variables (e.g. therapists'

self-schemas) may interact with client variables (e.g. clients' presenting issues) to predict affective, behavioral, and cognitive responses of therapists.

A common personality typology explored by depression researchers is dependency and self-criticism, also referred to as anaclitic and introjective personalities or sociotropy and autonomy, respectively. The following section examines theory and research surrounding this personality typology, and introduces an examination of affective, behavioral, and cognitive countertransferential reactions as a function of dependency and self-criticism self-schemata in the therapy relationship.

DIMENSIONS OF DEPENDENCY AND SELF-CRITICISM

Models and Descriptions

Researchers from various theoretical orientations have explored two patterns of personality thought to represent vulnerabilities or subtypes of depression. Despite the broad range of theoretical perspectives represented by these theorists, there is strong agreement that two subtypes of depression exist: dependency and self-criticism (Blatt, 1974), sociotropy and autonomy (Beck, 1983), and dominant other and dominant goal (Arieti & Bemporad, 1980). Significant attention has been placed on these subtypes representing a vulnerability to depression, and more recent studies are exploring dependency and self-criticism beyond the realm of depression vulnerability research. This section explores this typology from cognitive, attachment, and psychoanalytic perspectives.

Drawing from Freud's ideas surrounding interpersonal relatedness and the self, Blatt and Shichman (1983) define this typology as anaclitic and introjective. Anaclitic refers to a personality organization focused on interpersonal relatedness, whereas introjective focuses on self-definition. Ideally the introjective and anaclitic dimensions in the individual develop and synthesize over time, enabling the individual to form positive interpersonal connections and an integrated sense of self. When the individual is faced with recurrent obstacles to this process, he/she may fixate on one dimension at the expense of the other. In the absence of any corrective experience, the individual will repeat this mode of behavior until he/she develops an unhealthy preoccupation with inter-relatedness or a sense of self (Blatt & Shichman, 1983).

Blatt (1990) suggests psychopathology may be thought of as an overemphasis on inter-relatedness, which sacrifices a sense of self, or conversely, an overemphasis on sense of self that sacrifices success at interpersonal relationships. More specifically, Blatt (1990) states:

> [E]xaggerated and distorted preoccupation about satisfying interpersonal relations, to the neglect of the development of concepts of self, defines the psychopathologies of the anaclitic configuration-the infantile and hysterical syndromes. Exaggerated and distorted concerns about the definition of self, at the expense of establishing meaningful interpersonal relations, defines the psychopathologies of the introjective configuration-paranoid, obsessive-compulsive, introjective depressive, and phallic narcissistic disorders. (p.312)

Blatt and colleagues (c.f. Blatt, D'Afflitti, & Quinlan, 1976) conducted several studies of depression in young adults which support the role of introjective

and anaclitic personality in depression. Blatt and colleagues created a 66-item measure, the Depressive Experiences Questionnaire (DEQ), which assesses 'Not symptoms of depression, but rather items that reflected how depressed individuals feel about themselves and others and the everyday issues that concern and preoccupy them" (p.314). Three factors were identified, yet two are most consistent with the introjective and anaclitic dimensions. Specifically, the authors suggest depression focuses around dependency or problems with connectedness (dependency) and/or conflicts surrounding self-criticism or self-esteem (self-criticism).

Bowlby (1969, 1973, 1977, 1980, 1988; as cited in Blatt, 1990) has drawn connections between attachment theory and these subtypes of depression in adulthood. Specifically, Bowlby suggests "compulsively self-reliant' and "anxiously attached" individuals possess a vulnerability to depression, with the former shunning relationships and those who seek them and the latter being overly reliant on connectedness. Zuroff, Moskowitz, and Cote (1999) suggest that an anxious attachment style may be associated with highly dependent individuals, and Zuroff and Fitzpatrick (1995) associate self-criticism with a fearful-avoidant attachment style.

Arieti and Bemporad (1980) identify subtypes of depressive personality based on clinical experience with 40 depressed clients over a 20-year period. Excessive reliance on interpersonal interactions that maintain self-esteem or relentless pursuit of goals represent two underlying organizations of depressive behavior. The former model suggests a theme of dependence may be associated with depression, based on a “dominant other type of ideology and relationship”

(p.1360). The depressed individual depends entirely on a significant other to provide his or her sense of self worth and fulfillment (Arieti & Bemporad, 1980). The individual receives comfort only through praise and punishment offered by an identified significant other and does not gain happiness independently. Arieti and Bemporad (1980) suggest two individuals form a "…bargain relationship in which the individual forgoes the independent gratification in return for the continued nurturance and support of the esteemed other" (p. 1361). In a case illustration, the authors describe a depressed client who "…had evolved a lifestyle of diligent work and obedience to obtain praise and support from her husband" (p.1361).

Arieti and Bemporad (1980) propose another model of depressive personality, the "dominant goal" type (p.1361). This model suggests a theme of personal achievement or excessive self-criticism may be associated with depression. "Dominant goal" depressives attach personal worth and life meaning to achievement of some high aspiration. These individuals believe attaining this goal will guarantee the adoration of others and will be life altering. For example, Arieti and Bemporad discuss the dominant-goal typology of a client: "He spoke of great aspirations of being awarded spectacular prizes and becoming director of a prestigious research institution. His being passed over for the job forced him to realize that he might never achieve his goals" (Arieti & Bemporad, 1980, p.1361-1362). Inevitably, all of the individual's goals are not successfully attained, therefore, the individual's sense of self deconstructs and depression follows.

Sociotropy and Autonomy: A Cognitive Perspective

Beck (1983) describes a socially dependent (sociotropic) and an autonomous type of depression. Sociotropy or social dependence "refers to the person's investment in positive interchange with other people. This cluster includes passive-receptive wishes (acceptance, intimacy, understanding, support, guidance) or narcissistic wishes (admiration, prestige, status). Individuality (autonomy) refers to the person's investment in preserving and increasing his independence, mobility, personal rights; freedom of choice, action, and expression; protection of his domain; and attaining meaningful goals" (p. 272). Beck suggests depression manifests in the sociotropic individual who is unable to satisfy his/her distorted need for interpersonal connectedness, or in the autonomous individual unable to reach goals necessary for maintenance of a strong sense of self. Beck and colleagues (1983) have developed the Sociotropy and Autonomy Scale (SAS) which measures these dimensions of depression.

Sociotropic and autonomous depressives also manifest different constellations of symptoms. Beck (1983) suggests sociotropic depressives' clinical presentation is marked by feelings of loss, deprivation, and loneliness. Sociotropic individuals experiencing depression are also more likely to cry, feel disliked by peers, and have co-existing symptoms of anxiety. However, sociotropic depressives have a more positive outlook on treatment and experience greater improvement when hospitalized. Autonomous depressives experience disinterest in activities and feelings of self-defeat and worthlessness. Treatment is viewed more negatively unlike for their sociotropic counterparts.

Several studies (c.f., Hammen, Marks, Mayol, & deMayo, 1985; Nelson, Hammen, Daley, Burge, & Davila, 2001) have explored dependency and self-criticism as a diathesis-stress model, in which stressors congruent with a particular personality style elicit distress. Another prospective proposed by Beck (1983), suggests these personality styles may operate like cognitive schemas, filtering schema-relevant information which influences individuals' cognition, emotions, and interpersonal behavior.

One line of research has examined interpersonal and self-critical styles in depression from a schema theory perspective. Hammen, Marks, Mayol, and deMayo (1985) used this typology to assess associations between schema-related and schema-nonrelated life events and depressive subtypes. Participants were identified as either dependent or self-critical schematic, and levels of depression and frequency of schema-related and schema-nonrelated life events were assessed over a four-month period. For example, a midterm examination for a person possessing an achievement schema represented a schema-related life event, whereas a social situation represented a schema-nonrelated life event for this person. Dependent and self-critical schematics were classified based on questions eliciting specific examples of achievement oriented or interpersonally oriented events which had occurred in the past month, consistent with the notion that recall for schema-related events will be higher than schema nonrelated events. Hammen and colleagues (1985) suggest that depressives with dependent/interpersonal schemata experienced heightened levels of depression when faced with stressful interpersonal life events. A less powerful relationship was found between depressive symptoms and achievement life events for depressives with achievement/failure schemata. This

investigation provides some support for depressive typologies proposed by others (c.f. Arieti & Bemporad, 1980; Beck, 1983; Blatt et al., 1976) and emphasizes the relationship between life events, schematic representation, and subtypes of depression. This study also represents an attempt to examine dependent and achievement constructs from a schema theory perspective.

A more recent study conducted by Nelson, Hammen, Daley, Burge, and Davila (2001) further supports the notion that dependency and self-criticism personality styles operate like cognitive schemas, thus influencing achievement and interpersonal experiences. In this study, Nelson and colleagues (2001) explore the role of dependent and self-critical personality styles in contributing to chronic stress in a sample of 115 women over 18 months. Results suggest chronic interpersonal stress is associated with need for control, an aspect of autonomy, and that sociotropy is associated with chronic stress surrounding achievement events. Nelson and colleagues (2001, p. 73) go on to state "This study extends the cognitive model to suggest that these personality styles function like schemas, activated by daily work and relationship experiences, which may actually affect behavior in dysfunctional ways, leading individuals to place emphasis on one domain while neglecting or performing less well in another." In view of this and other studies which have explored these personality styles in interpersonal relationships, it appears the therapeutic relationship may represent another context in which activation of these schemas influences behavior and cognition.

New Directions in Sociotropy/Autonomy Research

Sociotropy and autonomy have been examined exhaustively by depression researchers, nevertheless, many theorists view these constructs as two basic courses of development (c.f. Crosby-Ouimette, Klein, Anderson, Riso, & Lizardi, 1994). More recently, these constructs are considered personality dimensions as opposed to symptomology, which has sparked new lines of research surrounding autonomy and sociotropy.

Crosby-Ouimette and colleagues (1994) explored associations between Axis II personality disorders and sociotropy/autonomy (Beck, 1983) and dependency/self-criticism (Blatt, et al., 1976) constructs. One-hundred thirty-eight outpatients diagnosed with depressive or personality disorders completed the Personal Style Inventory (Robins, Ladd, Welkowitz, Blaney, Diaz, & Kutcher, 1994) and the Revised Depressive Experiences Questionnaire (Welkowitz, Lish, & Bond, 1985). Two structured clinical interviews were administered to diagnose participants' personality disorders. The authors examined relationships between these constructs and both categorical and dimensional measures of Axis II. disorders. Dependent, histrionic, and borderline traits correlated significantly with the sociotropy subscale of the PSI (PSI-S) and the dependency subscale of the RDEQ (RDEQ-D). Dependent and histrionic traits were significantly correlated with the PSI-S. Holding level of depression and autonomy/self criticism subscales constant, the RDEQ-D was significantly associated with dependent traits. Diagnoses of dependent, histrionic, and borderline personality disorders were significantly correlated with the PSI-S, and dependent personality disorder diagnoses were

associated with the RDEQ-D. Holding level of depression and autonomy constant, PSI-S correlated significantly with dependent and histrionic personality diagnoses.

Paranoid, narcissistic, obsessive-compulsive, schizoid, and passive aggressive characteristics correlated strongly with the autonomy sub scale of the PSI (PSI-A) and the self-criticism subscale of the RDEQ (RDEQ-SC), and these relationships remained holding level of depression and sociotropy/dependency constant. Only the PSI-A was associated with antisocial characteristics. Diagnoses of paranoid personality disorder were significantly associated with the PSI-A and the RDEQ-SC and remained significant after controlling for depression and the sociotropy/dependency subscales. PSI-A and RDEQ-SC had several significant correlations with the personality disorders measures in general. In conclusion, Crosby-Ouimette and colleagues (1994) suggest "the autonomous/self-critical style may encompass a broader, less specific, range of psychopathology than has previously been suggested" (p.747) and that "this construct may be a relatively nonspecific marker of general psychopathology" (p. 748).

Another line of research has explored interpersonal and achievement scales across several self-report measures, such as the DEQ, Dysfunctional Attitudes Scale (DAS), and Sociotropy/Autonomy Scale (SAS). Rude and Burnham (1993) found interpersonal scales of the DEQ, DAS, and SAS to be substantially correlated, but the same relationships were not detected among achievement scales of these instruments. To better understand the underlying structure of these instruments, the authors also conducted a factor analysis of items from the DEQ, DAS, and SES. Analysis yielded two underlying factors, Dependency and Performance Evaluation. Finally, Rude and Burnham (1993) explored the ability of each instrument's scales

or combination of scales to interact with scale-related life events to predict depression. With exception of the DAS, the interpersonal scales of each instrument interacted with frequency of interpersonal life events to predict depressive symptoms.

In a later study, Rude and Burnham (1995) conducted individual and combined factor analyses of dependency scales of the DEQ and SAS. Two factors emerged from the scales both separately and together: Connectedness and Neediness. Connectedness is defined as "a valuing of relationships and a sensitivity to the effects of one's actions on others" and Neediness is characterized by "anxious concerns regarding possible rejection" (p. 337). Additionally, Rude and Burnham (1995) observed relationships between these dimensions, gender, and depression. Specifically, Connectedness was related to gender but not to depression, and Neediness was associated with depression and not gender. Rude and Burnham (1995) conclude "Hence, the evidence here is that both of these widely used measures of dependency confound a psychological dimension (Connectedness) upon which women and men differ but which does not have observed negative consequences for adjustment, with one (Neediness) that is associated with depressive symptomology but not with gender" (p.337).

Role of Autonomy/Sociotropy in Social Interactions

A series of studies by Zuroff and colleagues has explored self-criticism and dependency dimensions as they relate to interpersonal processes. In a study on attachment style, Zuroff and Fitzpatrick (1995) suggest dependency in college students is associated with an anxious attachment style and self-criticism is

associated with a fearful-avoidant attachment style. These findings suggest maladaptive attachments with primary caregivers may predict excessive dependency or self-criticism in adult life.

Zuroff and deLorimier (1989) explored preference of romantic partners in college students as a function of dependency and self-critical personality styles. This study suggests college females with self-reported dependency traits are more drawn to potential mates with high intimacy needs as opposed to high achievement or masculinity needs. College females with self-reported self-criticism reported their ideal mate would have high achievement and masculinity needs. The authors suggest college females scoring high on self-report measures of dependency favor intimacy-oriented romantic partners and expressed high degrees of love in these relationships. However, dependency was not associated with satisfaction in the relationship. Zuroff and colleagues (1995) suggest "…because of their chronic feelings of insecurity, dependent subjects' feelings of love are not accompanied by heightened feelings of satisfaction" (p.544).

Fichman, Koestner, and Zuroff (1994) examined interpersonal problems in adolescents with dependent and self-critical personality styles. High levels of dependency in adolescents were associated with difficulty exercising assertiveness and carrying too much responsibility in relationships. Problems being gregarious and exerting too much power in relationships was associated with self-critical personality styles in adolescents.

Although consistent with previous literature surrounding these personality styles (e.g. Beck, 1983; Blatt, et al., 1976) these studies have generally examined college student's past romantic relationships as a function of dependency and self-

criticism. Zuroff, Stotland, Sweetman, Craig, and Koestner (1995) summarize findings examining interpersonal relationships in college students with dependent personality styles and state: "In summary, dependency has been associated with a focus on achieving and maintaining intimate relationships, inhibitions concerning behavior that might disrupt such relationships, and a conscious preoccupation with the danger of losing the relationship" (p.544). In describing studies of relationships of college students with self-criticism personality styles, the authors state: "self criticism has been associated with the avoidance of emotionally intimate relationships and with remaining distrustful, non-self-disclosing, and dissatisfied within those relationships that are established" (p.544).

Zuroff and colleagues (1995) point out that most of these studies used retrospective self-reports of college students' interpersonal relationships, therefore the authors conducted a study examining more specific, everyday interpersonal interactions of college students as a function of self-critical and dependent personality styles. Over a seven day period, 48 college students completed the Rochester Interaction Record in reference to every interpersonal interaction lasting 10 minutes or longer. Participants also completed a measure of mood at the end of each day and the DEQ prior to the study. Results suggest dependent personality was related to a higher number of, and more intimate interpersonal interactions.

Participants with self-critical personality styles saw interpersonal interactions as less positive, and a negative relationship between self-criticism and positive perception of interpersonal interactions remained holding level of dysphoria constant (Zuroff, et al., 1995).

Autonomy and sociotropy are often considered personality dimensions, however Whisman and Friedman (1998) suggest these constructs may be thought of as dysfunctional attitudes or cognitions. Previous research (c.f. Zuroff, et al. 1995) has examined relationships between social interactions and autonomy/sociotropy personality dimensions, yet they do not identify specific social problems tied to dysfunctional attitudes regarding self-criticism and autonomy or acceptance and approval (dependency). Therefore, Whisman and Friedman (1998) administered the Beck Depression Inventory (BDI; Beck, et al.1979), the Dysfunctional Attitudes Scale (DAS; Weissman & Beck, 1978) and the Inventory of Interpersonal Problems-Circumplex (IIP-C; Alden, Wiggens, & Pincus, 1990; as cited in Whisman and Friedman, 1998) to 390 undergraduate college students to explore relationships between problem social behaviors and these specific dysfunctional attitudes. Whisman and Friedman (1998) suggest several specific kinds of self-reported social problems are more associated with dysfunctional attitudes surrounding achievement and autonomy than acceptance and approval, as measured by the Performance Evaluation Scale of the DAS. Examples of these self-reported problem behaviors are domineering behavior, distrustful or angry behavior, problems receiving or giving affection to others, and social isolation.

This finding is consistent with several other studies suggesting self-criticism or autonomy is associated with problematic social interactions. Other researchers have explored associations between perfectionistic standards and poor treatment outcome in depressed clients, which has raised some question about the role of self-criticism in creating a strong therapeutic alliance (c.f. Whisman & Friedman, 1998; Zuroff, Sotsky, Martin, Sanislow, Blatt, Krupnick, & Simmens, 2000). The results

of this and previous studies support the notion that self-criticism is frequently tied to poor interpersonal interactions; and that the same may be true for therapeutic alliances.

A more recent discussion of dependency and self-criticism in the context of interpersonal interactions (Zuroff, Moskowitz, & Cote; 1999) suggests these personality subtypes may have implications for therapeutic interactions between therapist and client. For example, Zuroff and colleagues state "dependent individuals are intensely concerned with being esteemed as likable, yet insecure concerning their standing on that dimension" (1999, p. 233). In discussing self-critical individuals, Zuroff and colleagues state "emotionally intimate relationships are especially threatening for self-critics, because they fear that revealing their thoughts and feelings will lead to disapproval and rejection." Dependency and self-criticism seem to influence several aspects of intimate relationships, including but not limited to, level of self-disclosure, perceived acceptance, and safety within the relationship. These factors are of significant importance to the therapeutic relationship, therefore dependency and self-criticism traits present in therapists and clients may represent a new type of relationship to explore within this area of literature.

Blatt (1990) comments on this notion in a review on anaclitic and introjective subtypes: "Data from two studies of change during the treatment process indicate that patients excessively preoccupied with issues of interpersonal relatedness (anaclitic patients) and those excessively preoccupied with self definition, individual autonomy, prerogatives, and control (introjective patients) change in different ways in the treatment process and are differentially responsive to

different forms of therapy" (p. 319-320). Distinctions between treatment responses of anaclitic verses introjective clients are important to make, however no known research has examined therapists' responses in therapy as a function of their own or the client's introjective or anaclitic styles. In examining these personality styles from a cognitive and interpersonal framework, Whisman and Friedman (1998) suggest " cognitions about the self and others are believed to affect interpersonal behaviors and events, which in turn elicit responses that serve to confirm and maintain belief systems" (p. 150). Zuroff (1992) goes on to suggest integrating cognitive and interpersonal theory enhances understanding of how "cognitive vulnerabilities affect not only one's interpretations of events but also the kinds of interactions and events to which one is exposed" (p. 276).

Dependency/Self-Criticism Traits and Therapeutic Effectiveness

Another line of research alludes to an association between the introjective/anaclitic personality styles and therapeutic effectiveness. As mentioned in a previous section, several qualitative analyses have focused on characteristics of master therapists. Jennings and Skovholt (1999) identified three key areas of attributes (cognitive, emotional, relational) with each category consisting of three smaller subcategories. One area, the relational domain, highlights inverse relationships between overly dependent and/or self-critical personality and effectiveness as a therapist. In describing subcategories of the relational domain, the authors report "Master therapists possess strong relationship skills" and "Master therapists appear to be experts at using their exceptional relationship skills in therapy" (p. 7-8). Effectiveness as a therapist also appears to be negatively

associated with an overly self-critical personality style. In describing emotional characteristics of master therapists, Jennings and Skovholt (1999) state "As another indicator of emotional health, respondents seem to have a healthy perspective on their sense of importance. They appeared to be comfortable with themselves and held a realistic perspective on their importance in the world. In short, respondents seemed to have struck a healthy balance between confidence and humility" (p.7).

Despite research suggesting a positive self-concept and strong interpersonal skills are essential qualities of effective therapists, no known research has explored introjective and/or anaclitic styles in therapists. More specifically, introjective and/or anaclitic schemata in therapists have not been explored, and how these schema subtypes may predict countertransferential responses to clients possessing similar issues. The following section describes the proposed dissertation, which will explore affective, behavioral, and cognitive countertransferential reactions to dependency and self-criticism client issues from a schema-theory perspective.

PURPOSE OF PROPOSED DISSERTATION

Taking these diverse areas of literature together, several new questions arise. First, clinical and social cognitive researchers have investigated the role of schemata in personality and social interaction; however, no known research has explored the role of schemata strictly in the therapy relationship. Specifically, affective, behavioral, and cognitive countertransferential reactions of therapists have not been explored from a schema theory perspective. Dependent and self-critical schema subtypes have received some attention in depression vulnerability research, yet no known research has examined the effects of these personality dimensions in

therapists. Young's early maladaptive schemata provide a conceptual framework from which to explore schemata in therapists, while gaining insight into early maladaptive schemata associated with dependent and self-critical personality styles.

Studies of effective therapists suggest exceptional interpersonal skills and a positive self-concept are central to successful psychotherapy. One reason for this finding may be that therapists with some level of dependent and/or self-critical personality exhibit countertransferential reactions, which are thought to be associated with poor treatment outcome. It seems plausible that a match or mismatch of dependency and self-criticism styles between therapist and client may differentially predict therapists' reactions during treatment.

This dissertation examined countertransference from a schema theory perspective, specifically, affective, behavioral, and cognitive reactions of therapists' to clients possessing dependent and self-critical issues as a function of therapists' own dependency and self-criticism schemata. Fifty therapists listened to audiotaped vignettes of clients illustrating dependency and self-criticism presenting issues. Affective measures included degree of warmth, liking, affection, and anxiety felt toward each client. Behavioral measures included verbal responses made to clients in the vignettes. Cognitive measures included therapists' recall of information presented in the vignettes; and therapists' beliefs regarding clients' likelihood for improvement, optimism about treatment, and goals for treatment. This study also explored the role of therapists' distress, professional experience, and personal psychotherapy in predicting countertranferential responses to clients with issues congruent to therapists' schemas. Relationships between Young's early maladaptive schemata and sociotropy and autonomy, as measured by the YSQ-L and Personal

Style Inventory-II (Robins, Ladd, Welkowitz, Blaney, Diaz, & Kutcher, 1994) respectively, were also explored.

Chapter 2:

Questions and Hypotheses

QUESTION 1:

In what way do therapists' dependency schemas predict affective countertransferential responses toward clients focusing on dependency issues?

Hypotheses for affective responses

It was expected that therapists' dependency schemas would predict anxiety experienced with clients illustrating dependency issues.

It was expected that therapists' dependency schemas would predict warmth, liking, and affection experienced with clients illustrating dependency issues.

QUESTION 2:

In what way do therapists' dependency schemas predict verbal countertransferential responses toward clients focusing on dependency issues?

Hypothesis for behavioral responses

It was expected that therapists' dependency schemas would predict therapists' verbal responses toward clients with dependency issues.

QUESTION 3:

In what way do therapists' dependency schemas predict therapists' cognitive responses toward clients focusing on dependency issues?

Hypotheses for cognitive responses

It was expected that therapists' dependency schemas would predict therapists' ability to recall dependency-oriented client information.

It was expected that therapists' dependency schemas would predict therapists' optimism about treatment with clients focusing on dependency issues.

It was expected that therapists' dependency schemas would predict therapists' beliefs that clients focusing on dependency issues were likely to improve.

It was expected that therapists' dependency schemas would predict importance therapists place on dependency-oriented treatment goals.

QUESTION 4:

In what way do therapists' self-criticism schemas predict affective countertransferential responses toward clients focusing on self-criticism issues?

Hypotheses for affective responses

It was expected that therapists' self-criticism schemas would predict anxiety experienced with clients illustrating self-criticism issues.

It was expected that therapists' self-criticism schemas would predict warmth, liking, and affection experienced with clients illustrating self-criticism issues.

QUESTION 5:

In what way do therapists' self-criticism schemas predict verbal countertransferential responses toward clients focusing on self-criticism issues?

Hypothesis for behavioral responses

It was expected that therapists' self-criticism schemas would predict therapists' verbal responses toward clients with self-criticism issues.

QUESTION 6:

In what way do therapists' self-criticism schemas predict therapists' cognitive responses toward clients focusing on self-criticism issues?

Hypotheses for cognitive responses

It was expected that therapist's self-criticism schemas would predict therapists' ability to recall self-criticism-oriented client information.

It was expected that therapists' self-criticism schemas would predict therapists' optimism about treatment with clients focusing on self-criticism issues.

It was expected that therapists' self-criticism schemas would predict therapists' beliefs that clients focusing on self-criticism issues were likely to improve.

It was expected that therapists' self-criticism schemas would predict importance therapists place on self-criticism-oriented treatment goals.

QUESTION 7:

What is the role of therapists' professional experience, personal psychotherapy and level of distress in predicting affective, behavioral and cognitive countertransferential reactions with clients presenting with schema-congruent presenting issues?

Hypotheses:

It was expected that therapist's degree of professional experience would predict therapists' degree of countertransferential reactions.

It was expected that therapist's amount of personal psychotherapy would predict therapists' degree of countertransferential reactions.

It was expected that therapist's level of distress would predict therapists' degree of countertransferential reactions.

QUESTION 8:

Which of Young's early maladaptive schemata (1990) best capture the dependency and self-criticism constructs as measured by the Revised Personal Style Inventory-II?

Chapter 3:

Method

This study explored the role of therapists' dependency and self-criticism schemata in predicting therapists' countertransferential responses to clients with schema-congruent or schema-incongruent presenting issues. Therapists' affective responses, verbal behavior, and cognition in response to clients with dependency or self-criticism issues represented the countertransferential reactions in question. This issue is important because effective management of countertransferential feelings and behaviors has been associated with positive treatment outcome; and strong interpersonal skills and self-concept have been associated with therapist expertise (Jennings & Skovholt , 1999). Therapists' management of dependency and self-criticism schemata may influence therapists' efficacy and role in therapy. This dissertation explored these issues.

OVERVIEW OF STUDY

Fifty therapists-in-training and professional therapists participated in this study. Therapists listened to audio taped vignettes of clients with issues that were either predominantly related to dependency or self-criticism. All therapists listened

to five vignettes: one practice vignette, two vignettes illustrating dependency issues, and two vignettes illustrating self-critical issues.

Likert-type questions and audio taped verbal responses were used to assess therapists' affective, behavioral, and cognitive countertransferential responses to dependency and self-criticism issues. Affective measures included degree of warmth, liking, empathy, affection, anxiety, and boredom felt toward each client. Behavioral measures included verbal responses made to clients in the vignettes. Cognitive measures included therapists' recall of information presented in the vignettes; and therapists' beliefs regarding clients' likelihood for improvement, difficulty expected in conducting treatment, optimism about treatment, and goals for treatment. At the conclusion of this study, therapists completed a demographic measure and self-report measures of early maladaptive schemata, dependency and self-criticism traits, and current distress. The investigator also completed a brief interview with each therapist.

PARTICIPANTS

Therapists were graduate students and professionals in social work, clinical, counseling, and school psychology. Each participant had at least one-year of individual therapy experience. Forty therapists were recruited and participated in Austin, Texas, and ten therapists were recruited and participated in Houston, Texas. The investigator recruited participants via email, telephone correspondence, or in person. Therapist participants were told the following when asked to participate: "You will be asked to listened to audiotaped case vignettes and provide written and verbal responses to each vignette. The study will take approximately 1

1/2 hours to complete." See Appendix B for a summary of the sample's demographic characteristics.

INSTRUMENTS

The research procedures were approved by the Department of Educational Psychology Departmental Review Committee at The University of Texas at Austin and the University of Houston Committee for the Protection of Human Subjects. Guidelines for human research provided by the American Psychological Association and The University of Texas Institutional Review Board for the Protection of Human Subjects were also followed.

Six-item Short Form of the State Trait Anxiety Inventory

The six-item short-form of the Spielberger State-Trait Anxiety Inventory (STAI-6; Marteau & Bekker, 1992) was used to measure therapists' state anxiety following presentation of each audio taped vignette. The scale consists of 6 items rated on a 4-point Likert scale, 1 (not at all) to 4 (very much so). Higher scores indicate elevated momentary anxiety. Examples of state-anxiety items are "I feel anxious" and "I feel comfortable" (see Appendix C).

Spielberger (1976) described the State Anxiety scale as a "sensitive indicator for the transitory anxiety that is experienced…in counseling" (p.9). Internal consistency ratings range from .83 to .96 (Dreger, 1978). Test-retest reliability is low as the STAI-S assesses state or situational anxiety, and reliability values include .16 to .33 for 1 hour, .27 to .54 over 20 days, and .31 to .33 over 104 days (Dreger,

1978). Previous research using the STAI-S has demonstrated that STAI-S items and total scores differentiate between "stressful and non-stressful experimental conditions" (Spielberger, 1970, p.484). The STAI-S has strong external validity as STAI-S scores have been shown to change and correlate with other state measures of anxiety under similar experimental conditions (Spielberger, et al., 1983; as cited in Sharkin & Gelso, 1993).

Marteau and Bekker (1992) created the six-item short form of the STAI-S. In an item selection study, the authors selected smaller subsets of items from the full version of the STAI-S and correlated scores of these items with scores from the full version of STAI-S. Scores from the short-forms and full version forms were as follows: r =.96 for 10 items, r =.96 eight items, r = .95 for six items, r = .91 for four items, and r = .84 for two items. Reliability for the six-item short form is .82. Marteau and Bekker (1992) also performed comparisons of the six-item short form with the 20 and 14-item versions of the STAI-S using paired *t* tests. No differences in mean scores were detected between those using the full-form versions of the STAI-S and those using a six-item prorated version of the STAI. No differences in mean scores were detected between the six-item prorated version and the means prorated from the 14 remaining STAI-S items. Using a sample in which state anxiety was experimentally induced, the authors also compared STAI scores collected using the six-item short form and STAI-S full version form. This sample's mean scores on the six-item short form of the STAI (47.7; SD=15.8) were similar to scores obtained on the full version of the STAI-S (46.4; SD=14.8).

Brief Symptom Index

This measure was used to assess level of distress at the time of the experiment. The BSI (BSI; Derogatis & Melisaratos, 1983) is a brief psychological self-report symptom scale designed to assess psychological symptoms of psychiatric inpatients and nonpatients. The BSI was based on another self-report measure of psychological distress, the Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1975; as cited in Derogatis & Melisaratos, 1983). The scale consists of 53 items to be answered on a 5-point Likert-type scale: 0-not at all, 1-a little bit, 2-moderately, 3-quite a bit, 4-extremely (see Appendix D). Respondents are assessed on nine dimensions (e.g., somatization, interpersonal sensitivity) or in one of three global indices (i.e., the Global Severity Index, Positive Symptom Distress Index, and Positive Symptom Total). Respondents are asked to select the answer choice which best describes "How much that problem has distressed or bothered you during the past 7 days including today." Sample items include: "Trouble falling asleep," "Never feeling close to another person" and "Getting into frequent arguments."

Psychometric analyses suggest the BSI is an acceptable and shorter alternative to the SCL-90-R. Test-retest and internal consistency reliabilities are strong for the primary symptom scales of the BSI. Internal consistency coefficients across the nine subscales range from .71 to .85, and test-retest correlations over a two-week period range from .68 to .91 (Derogatis & Melisaratos, 1983). The empirically derived factor structure of the BSI is highly associated with the rationally derived factor structure of the SCL-90-R. The BSI has strong convergent validity as there appears to be high convergence between BSI scales and analogous dimensions of the MMPI-2.

Young Schema Questionnaire – Long Form

The Schema Questionnaire (YSQ-L; Young, 1990) is a 205-item self-report inventory used to assess 16 early maladaptive schemata (EMS). This measure was used to assess schemata in therapists and explore relationships between Young's EMS (1990) and sociotropy and autonomy as measured by the Revised PSI. Therapists rated each self-descriptive statement on a 6-point Likert scale (1 = Completely untrue of me, 2 = Mostly untrue of me, 3 = Slightly more true than untrue of me, 4 = Moderately true of me, 5 = Mostly true of me, 6 = Describes me perfectly) (see Appendix E). Clinical experience with challenging and/or long-standing clients was used as the theoretical bases from which SQ items were constructed (Schmidt, Joiner, Young, & Telch, 1995). The Young Schema Questionnaire (1990) assesses Young's original set of 16 maladaptive schemata and a revised version has not been created for Young's (1999) current list of 18 EMS.

Factor analysis of the SQ was conducted (Schmidt, Joiner, Young, & Telch, 1995) using undergraduate students at a large state university (N=1,129). This sample was divided into two groups in order to perform cross-validation analyses of the factor structure (N = 575, N = 554). Using SPSS's principal-components analysis (PCA) to perform factor analyses of the SQ, analysis of Sample 1 indicates 17 factors are present in the SQ. Of those 16 schemata derived by Young (1994), 15 schemata were detected in Sample 1. Money Worries and Loss of Control Fears were added factors detected in the analyses, and represent more distinct aspects of schemata previously derived by Young (1994). Cross validation of this factor structure was conducted via administration of the SQ to Sample 2. Thirteen of the 17 factors identified in Sample 1 were found again in Sample 2, with 12 of the 13

factors derived by Young (1994) being detected again in Sample 2. Items representing the other four schemas derived by Young (1994) emerged on other theoretically relevant factors. Loss of Control Fears, found in Sample 1, was also detected in Sample 2. As a result of this analysis, Schmidt and colleagues renamed several of Young's original early maladaptive schemata to concisely identify the central characteristics of the 13 underlying cognitive structures.

Test-retest reliability data was collected using a sample of undergraduate students (N = 85). Following assessment at Session 1, participants completed the SQ three weeks later. Schmidt and colleagues calculated both test-retest coefficients and Cronbach's alpha internal consistency coefficients for the 13 factors. Test-retest coefficients ranged from .50 to .82 and alpha coefficients ranged from .83 to .96, suggesting the SQ has good reliability properties (Schmidt, Joiner, Young, & Telch, 1995).

Means and standard deviations were also gathered for subjects scoring low on the Personality Diagnostic Questionnaire-Revised (PDQ-R; Hyler & Rieder, 1987; as cited in Schmidt, Joiner, Young, & Telch, 1995), a self-report measure of assessing symptoms of personality disorders. Means and standard deviations of the overall and sub scales on the YSQ-L for this population include: Total YSQ-L score (M = 283.6, SD = 53.4), Incompetence/Inferiority (M = 13.0, SD = 3.4), Emotional Deprivation (M = 22.9, SD = 7.4), Defectiveness (M = 30.9, SD = 7.8), Insufficient Self-Control (M = 39.1, SD = 10.7), Mistrust (M = 27.5 , SD = 8.2), Self-Sacrifice (M = 43.3, SD = 11.7), Unrelenting Standards (M = 42.3, SD = 13.3), Abandonment (M = 14.1, SD = 5.0), Enmeshment (M = 9.2, SD = 3.2),

Vulnerability (M = 12.4, SD = 3.5), Dependency (M = 16.1, SD = 4.5), Emotional Inhibition (M = 8.3, SD = 3.9), and Fear of Losing Control (M = 4.4, SD = 2.2).

Revised Personal Style Inventory

The Revised PSI (PSI; Robins, Ladd, Welkowitz, Blaney, Diaz, & Kutcher, 1994) was used to assess levels of sociotropy and autonomy; and associations between EMS as measured by the YSQ-L (Young, 1990) and sociotropic and autonomous traits. Previous measures of interpersonal and achievement vulnerabilities have some psychometric and theoretical problems, therefore Robins, Ladd, Welkowitz, Blaney, Diaz, and Kutcher (1994) developed the Revised Personal Style Inventory. The authors gathered and modified items from existing measures of interpersonal and achievement vulnerabilities such as the Depressive Experiences Questionnaire (DEQ; Blatt, D'Afflitti, & Quinlan, 1976), the Dysfunctional Attitudes Scale (DAS; Weissman & Beck, 1978), and the Sociotropy and Autonomy Scales (SAS; Beck, Epstein, Harrison, & Emery, 1983). Results from five separate studies examining factor structure, internal consistency reliability, test-retest stability, and convergent and discriminant validity were used in the development of the Revised PSI. The authors suggest the Revised PSI has a strong factor structure, good internal consistency, and test-retest stability (Robins, et al., 1994).

The Revised PSI or PSI II consists of 48 items designed to measure dimensions of sociotropy and autonomy. The PSI Sociotropy and Autonomy Scales consist of 24 items each, with a 6-point Likert rating scale (strongly

disagree, disagree, slightly disagree, slightly agree, agree, and strongly agree) (see Appendix F). Scale scores are determined by summing the ratings given to each item. Scores range between 24 and 144 points for each subscale and between 48 and 288 points for the entire scale. The item stems were designed to represent "first person statements concerning one's needs, attitudes, perceptions, feelings, and behavior" (Robins, et al., 1994). The Sociotropy dimension is comprised of three smaller subscales: Concern for what others think, Dependency, and Pleasing Others; and the Autonomy dimension is comprised of Need for Control, Perfectionism/Self-criticism, and Defensive Separation subscales. Means and standard deviations for the Sociotropy and Autonomy subscales were gathered using a sample of 411 undergraduate students whom completed the Revised PSI-II in a large group testing sessions and are as follows: Sociotropy (M = 95.8, SD = 15.9) and Autonomy (M = 82.6, SD = 15.1).

Test-retest reliability for a 5 to 13 week period has been reported for each scale, at .80 for Sociotropy and .70 for Autonomy (Robins, et al., 1994). Robins and colleagues (1994) suggest the Revised PSI scales have strong construct validity relative to other measures of autonomy and sociotropy assessed thus far, such as the SAS, DEQ and RDEQ. Construct validity was determined among scales of the Revised PSI, the Revised DEQ (RDEQ; Robins, 1985) and the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). The correlation between the Sociotropy and Autonomy Scales of the Revised PSI was .21 ($p < .01$), suggesting these factors measure two distinct constructs.

Demographic Information Sheet

Participants provided their gender, ethnicity, age, highest currently held academic degree, type of academic degree currently pursued, types of licensures and credentials, years of therapy experience, and years of personal therapy. Role of training experience and years of personal therapy in predicting countertransference was assessed; therefore these two demographic items are used in analyses (see Appendix G).

Brief Interview

The investigator conducted this interview at the conclusion of the study. Therapists described key principles or theoretical orientations that guide how they conduct therapy and themes observed in therapy with clients. Therapists described life and/or training experiences that inform how they address dependency and/or self-criticism issues in therapy. The aim of these questions was to gather information about the origins of schemas in order to distinguish between personal and/or training experiences that formed dependency and self-criticism schemata in therapists. Schemas may be formed from experiences in childhood (e.g., developing a self-criticism schema from parental criticism as a child) or from professional experiences (e.g., being trained in a theoretical orientation emphasizing interpersonal relatedness) (see Appendix H).

STIMULUS MATERIALS

Five audio taped case vignettes were created to illustrate five clients: one brief practice vignette and four experimental vignettes (two self-critical/autonomy vignettes and two dependency/sociotropy vignettes.) The practice vignette was three to four minutes in length, and each of the remaining four vignettes were five to seven minutes in length.

Creation of Vignettes

Four actors portrayed clients in the dependency and self-criticism vignettes. Each actor portrayed one client with treatment issues predominantly related to dependency or self-criticism. The investigator met with each actor for one hour prior to taping the vignette. Each actor portrayed a Caucasian female client between the ages of 18 and 25 years. Actors were given verbal and written information describing self-critical/autonomous or dependent/sociotropic personality styles and the investigator discussed the personality type in depth with each actor. With each actor, the investigator created the content of the vignettes based on illustrations of clients presented in literature describing the self-critical and dependency subtypes. At a second meeting, the vignette was rehearsed and taped. Actors were taped in such a way that therapist participants were under the impression of being the therapist with whom the client is talking (c.f. Sharkin & Gelso, 1993). The vignettes were presented (e.g., dependency and self-criticism issues) in one of two orders, with the practice vignette presented first in both orders.

Content of Dependency Vignette

The dependency vignettes portrayed clients feeling helpless, rejected, or dependent on others to meet their emotional needs. One vignette portrayed a client who had recently broken up with her boyfriend. The client discussed efforts to gain her boyfriend's love by providing for his financial needs and overlooking his seeking intimacy outside the relationship. The other vignette portrayed a client who recently learned that her family was moving and was feeling alienated by her best friend. This client discusses her attempts to win approval from her friend and desire to leave college to be with her family and maintain a connection with her younger sister (see Appendix C).

Content of Self-Criticism Vignette

The self-criticism vignettes portrayed clients expressing self- criticism and anger in response to academic or professional rejection. One vignette portrayed a client who was not awarded a fellowship and questions her academic success and relationship with her academic advisor. This client explored her social isolation as a result of her focus on academic pursuits. The other vignette portrayed a client who was not selected for a job promotion, and questioned her colleagues' perceptions of her and her likelihood for success. This client explored her social isolation as a result of her focus on career advancement (see Appendix C).

Content of Practice Vignette

In the practice vignette, the investigator portrayed a client adapted from a case vignette constructed by Rochlen (2000). The client in the practice vignette focuses on career-decisions and familial pressures to select a prestigious career (see Appendix C).

Selection of Clients' Names

Names for the five clients illustrated in the vignettes were selected from Lawson's study (1980) which explored stereotypes and attributes associated with names of men and women. Based on Osgood's Semantic Differential Technique (1957; as cited in Lawson, 1980), Lawson rated men and women's names on the following dimensions: Good, Bad, Strong, Weak, Active, and Passive. For this study, the investigator selected five womens' names with comparable ratings on these dimensions.

Expert Rating of Vignettes

Four doctoral-level counseling and clinical psychologists rated each client on several dimensions. Raters assessed each client on dimensions of friendliness, likeability, sociability, and warmth using a 6-point scale ranging from "not very" to "very." Raters completed three Likert-type questions rating the degree to which clients relayed conflicts and problems in a realistic manner, were authentic and

believable, and could be imagined being seen in therapy (see Appendix I). To ensure that each vignette accurately illustrated self-criticism or dependency issues, judges rated the degree to which each vignette portrayed the issue (self-criticism or dependency) it purported to illustrate (see Appendix I). Interrater agreement was calculated across judges and is presented in Chapter IV.

MEASUREMENT OF THE DEPENDENT VARIABLES

Based on studies of countertransference conducted by Hayes and Gelso (1993), Sharkin and Gelso (1993), and Gelso, Fassinger, Gomez, and Latts (1995), therapists' affective, behavioral, and cognitive responses were assessed in reaction to dependency and self-criticism issues presented in audio taped vignettes.

Affective Assessment

Therapists' affective responses to the vignettes were assessed at two different points during this study. Therapists' warmth, liking, empathy and state anxiety in reaction to clients was assessed immediately following each vignette (see Appendix C). Following presentation of all five vignettes, additional ratings of therapists' reactions (dislike, affection, anxiety, and boredom) were obtained for each client (see Appendix J).

Anxiety Questions. Immediately following each vignette (e.g., dependency, self-criticism, practice vignette), therapists completed the STAI-6 (Marteau & Bekker, 1992). The STAI has been used in several studies of countertransferential reactions (c.f., Gelso, Fassinger, Gomez, & Latts, 1995; Hayes & Gelso, 1993; Sharkin & Gelso, 1993). Studies of countertransference have measured therapists'

state anxiety as anxiety has been negatively correlated with perceptions of counseling performance (Bandura, 1956), perceptions of therapist empathy (Bergin & Jasper, 1969), and outcome of therapy (Kelly, Hall, & Miller, 1989).

Therapists' anxiety in reaction to each client was assessed again after presentation of all five vignettes. Therapists were given the written instruction: "Please answer the following question(s) regarding (client's name)." This item asked therapists to rate on a scale of 1 (not at all) to 4 (very much): "To what extent does (client's name) make you feel anxious?" (see Appendix J).

Warmth/liking/affection Questions. Therapists responded to two Likert-type questions immediately following presentation of each vignette to assess degree of warmth and liking felt toward the client. Therapists were given the written instruction "Please answer the following four question(s) with respect to (client's name) using this 6-point scale." These items asked therapists to rate on a scale of 1 (strongly disagree) to 6 (strongly agree): "I feel warmth toward the client I just heard in the audio tape" and "I like the client I just heard in the audio tape" (see Appendix C).

Therapists completed two questions regarding their affection and liking for each client after presentation of all five vignettes. Therapists were given the written instruction: "Please answer the following question(s) regarding (client's name)." These items asked therapists to rate on a scale of 1 (not at all) to 4 (very much): "To what extent do you dislike (client's name)?" and "To what extent do you feel affectionate toward (client's name)?" (see Appendix J).

Therapists' degree of liking for each client was also measured through verbal responses provided during each vignette. As part of the behavioral assessment

portion of the study described below, judges rated degree of liking conveyed through therapists' verbal responses. Using a scale of 1(does not like) to 6 (likes very much), judges answered the question: " Overall, how much does the therapist like the client in this vignette?"

Boredom and Empathy Questions. Therapists responded to one Likert-type question immediately following presentation of each vignette to assess degree of empathy felt toward the client. Therapists were given the written instruction: "Please answer the following four question(s) with respect to (client's name)" using this 6-point scale." This item asked therapists to rate on a scale of 1 (strongly disagree) to 6 (strongly agree): "I feel empathy toward the client I just heard in the audio tape" (see Appendix C).

Therapists completed one question regarding their degree of boredom in response to each client. After presentation of all five vignettes, therapists were given the written instruction: "Please answer the following questions regarding (client's name)." This item asked therapists to rate on a scale of 1 (not at all) to 4 (very much): "To what extent does (client's name) make you feel bored?" (see Appendix J).

Behavioral Assessment

Verbal Responses. Therapists provided two verbal responses during each vignette that were recorded using a lapel microphone and a separate cassette tape recorder. The second tape machine recorded throughout this portion of the procedure. Therapists were given both verbal and written instruction for the verbal

response procedure (see Appendix K) at the beginning of the experiment. The verbal instruction was adapted from procedures used by Hayes and Gelso (1993). The investigator was present in the room during the practice vignette to ensure therapists understood and correctly performed the verbal response procedure.

At two predetermined stopping points during each vignette, a bell sounded on tape signaled the therapist to provide a verbal response to the client in the vignette. Therapists had thirty seconds for each response. Ten seconds before the response time ended, therapists were cued with a second bell signaling ten seconds of response time remained. At the end of the thirty-second response time, a third bell indicated the therapist had no more response time. The first verbal response occurred halfway through the vignette, and the second response occurred at the end of the vignette.

Coding of Verbal Responses. Three judges with graduate training and professional experience in counseling rated the degree to which therapists' responses helped clients explore dependency and self-criticism issues (see Appendix L). Judges listened to therapists' responses for each vignette and answered two questions per response. Using a six-point Likert-type scale of 1(not at all) to 6 (very much), judges answered the questions: "On a scale from 1 to 6, how much does the therapist's response help the client explore dependency issues?" and "On a scale from 1 to 6, how much does the therapist's response help the client explore self-criticism issues?" Using a scale of 1 (does not like) to 6 (likes very much), judges also answered the question: "Overall, how much does the therapist like the client in this vignette?" All three judges were blind to the purpose and procedures of the study.

The investigator met with each judge for two hours and provided each with verbal and written information surrounding the self-critical/autonomy and dependency/sociotropy constructs. The investigator discussed the subtypes in depth with each judge, and each judge completed practice ratings on vignettes. The investigator reviewed and discussed practice ratings with each judge before they were given permission to rate vignettes included in data analysis. Judges were paid five dollars per each rated participant. Interrater agreement was calculated across judges and is presented in Chapter IV.

Cognitive Assessment

Cognitive Recall. After the five vignettes were presented, therapists were given the written instruction: "Please write down three statements made by (client's name) that come to your mind. Use the first three statements that you can think of. Do your best to recall the particular words and phrasing (client's name) used" (see Appendix J). Therapists were given information about the client to remind them of the client they were asked to recall such as: "Margaret is the third client you heard. She is studying theater and dance, and makes mention of using the Internet." Therapists recalled information about clients in the order in which they were presented during the audio tape portion of the study. To shorten the length of the procedure, therapists did not recall information or respond to additional questions related to the practice vignette.

Coding of Cognitive Recall. The investigator rated the degree to which the recalled information was sociotropic or autonomous in content (see Appendix M). This measurement assessed therapists' tendency to recall information congruent

with his/her own schemata (e.g. dependency and/or self-criticism). One expert judge, a pre-doctoral intern in counseling psychology, provided ratings for a subset of the sample's cognitive recall responses. Interrater agreement was calculated across judges for these cases and is presented in Chapter IV.

Improvement/Optimism Toward Treatment. Therapists responded to one Likert-type question immediately following presentation of each vignette to assess therapists' beliefs the client would improve in therapy. Therapists were given the written instruction: "Please answer the following four question(s) with respect to (client's name) using this 6-point scale." This item asked therapists to rate on a scale of 1 (strongly disagree) to 6 (strongly agree): "I believe the client I just heard in the audio tape will improve a lot in therapy" (see Appendix J).

Therapists completed two additional questions regarding therapy outcome and level of difficulty in working with each client. After presentation of all five vignettes, therapists were given the written instruction: "Please answer the following questions regarding (client's name)." These items asked therapists to rate on a scale of 1 (not at all) to 4 (very much): "To what extent do you think it would be difficult to work with (client's name)?" and "To what extent are you optimistic about the outcome of therapy with (client's name)?" (see Appendix J).

Attitudes Toward Issues Important for Treatment. Therapists completed multiple-choice questions rating the extent to which they believed self-critical and/or dependency issues were an important focus for therapy with each client. After presentation of all five vignettes, therapists were given the written instruction: "Please answer the following questions about (client's name). To remind you, (client's name) is the fourth client you heard. She is studying theater and dance, and

makes mention of using the Internet." These items asked therapists to rate on a scale of 1 (not at all important) to 4 (very important):"To what extent do you think (client)'s interpersonal or dependency issues are important to focus on in therapy? and "To what extent do you think (client)'s achievement or self-definition issues are important to focus on in therapy?" (see Appendix N).

PROCEDURE

The investigator recruited participants via email, telephone correspondence, or in person. Therapist participants were told the following when asked to participate: "You will be asked to listen to audio taped case vignettes and provide written responses and verbal responses to each vignette. The study will take approximately 1 1/2 hours to complete." The investigator arranged a meeting time and location with each therapist. The study was completed at participants' homes, private offices, and office space at The University of Texas at Austin Department of Educational Psychology and the University of Houston Counseling and Psychological Services Center. Participants completed the study during individual appointment times which took one and one-half to two hours. The procedure for this study is presented in three parts.

Part I.

Therapists completed and signed the consent form (see Appendices O and P). The investigator asked therapists to place the lapel microphone on their clothing and explained that two tape recorders would be used to complete this portion of the

study. The investigator read the script of instructions for the vignette-portion of the procedure (see Appendix K). Procedures for the vignette-portion of this study were modeled after previous studies of countertransference (c.f. Gelso, Fassinger, Gomez, & Latts, 1995; Hayes & Gelso, 1993; and Sharkin & Gelso, 1993).

Prior to presentation of each vignette, therapists read written instructions for the procedure. These instructions were also read on audio tape prior to each vignette, therefore therapists read along with instructions presented on audio tape (see Appendix C). Prior to each vignette, therapists silently read one paragraph of background information about the client whom they were about to hear (see Appendix C).

The first vignette was a practice vignette to familiarize therapists with the verbal response procedure. This vignette was shorter than the remaining vignettes and lasted three to four minutes. Therapists provided verbal responses to the practice vignette using procedures described in an earlier section. The investigator was present in the room during the practice vignette to ensure therapists understood the verbal response procedure. When the practice vignette was completed, the investigator left the room and asked the therapist to notify the investigator when this portion of the study was completed.

The remaining four vignettes (e.g. dependency and self-criticism) were presented in one of two orders. Therapists listened to each vignette and provided verbal responses into a separate tape recorder. Following presentation of each vignette and recording of therapists' verbal responses, therapists completed four Likert-type items and the STAI-6 (see description under Measurement of Dependent Variables). Two of the Likert-type items assessed therapists' degree of warmth and

liking toward the client; one item assessed therapists' degree of empathy for the client; and the remaining item assessed therapists' beliefs regarding the client's likelihood for improvement. The STAI-6 was completed following the four Likert-type items (see Appendix C). When this portion of the procedure was completed, the investigator entered the room and collected the study materials.

Part II.

The investigator provided therapists with a paper-pencil distracter task and instructed therapists they would have two minutes to complete the task. Therapists were asked to find words embedded in a matrix of letters to provide distraction from material presented in the vignettes. After the distracter task was completed, therapists completed the cognitive recall task for each vignette. Therapists also completed six Likert-type items that assessed affective and cognitive reactions toward each vignette (see description under Measurement of Dependent Variables). Therapists also completed multiple choice questions that assessed attitudes regarding treatment goals for each client (see Appendix N).

Part III.

Following Part II, therapists completed the demographic form, the Young Schema Questionnaire- Long Form (YSQ-L; Young, 1990), the Revised Personal Style Inventory-II (PSI-II; Robins, Ladd, Welkowitz, Blaney, Diaz, & Kutcher, 1994), and the Brief Symptom Inventory. The YSQ-L, Revised PSI, and BSI were

presented in one of two orders. The investigator then completed the Brief Interview with each therapist.

Therapists were given verbal and written debriefing about the study (see Appendix Q) and asked not to discuss the study with fellow students or faculty until the project had been completed. Therapists were invited to call the investigator for feedback regarding their responses.

Chapter 4:

Results

It was expected that therapists' dependency and self-criticism schemata would predict countertransferential reactions to clients with schema congruent presenting issues. Dependent measures included various affective indices, therapists' verbal responses, cognitive recall of content presented during each vignette, and therapists' beliefs about clients' treatment outcome. This study also explored the role of therapists' professional experience, personal psychotherapy, and level of distress in predicting countertransferential responses to clients with schema-congruent presenting issues. Because no known measure of dependency and self-criticism schemata exists, early maladaptive schemata (EMS; Young, 1990) associated with dependency and self-criticism as measured by the Revised Personal Style Inventory-II (PSI; Robins, Ladd, Welkowitz, Blaney, Diaz, & Kutcher, 1994) were identified and used in linear regression models to predict therapists' countertransferential reactions to schema-congruent presenting issues.

DESCRIPTIVE STATISTICS

Means, standard deviations, and internal consistency coefficients for subscales and total scores of the YSQ-L, BSI, and PSI-II are presented in Table 2.

Therapists' scores on the YSQ-L, BSI, and PSI-II were normally distributed. Pearson correlation coefficients were computed among Young's 16 EMS, the dependency and self-criticism sub scales of the Revised PSI-II, and the BSI. Appendix R presents Pearson Correlation Coefficients among subscales of the YSQ-L, BSI, and PSI-II for this sample.

Table 2

Descriptive Statistics of YSQ-L, BSI, and Revised PSI-II

Scale	Mean	S.D.	Alpha
YSQ Subscales:			
Emotional Deprivation	15.34	6.77	.93
Abandonment	29.59	10.00	.91
Mistrust/Abuse	28.33	7.97	.88
Social Isolation	17.02	6.58	.89
Defectiveness/Shame	21.29	7.42	.92
Social Undesirability	15.86	5.39	.83
Failure	14.83	6.23	.92
Dependence	23.56	8.41	.91
Vulnerability to Harm	23.34	7.46	.88

Enmeshment	14.76	5.12	.89
Subjugation	17.66	5.98	.87
Self-Sacrifice	45.20	11.57	.86
Emotional Inhibition	4.00	5.38	.87
Unrelenting Standards	44.22	12.63	.90
Entitlement	21.88	6.64	.84
Insufficient Self-Control	28.50	9.75	.90
YSQ Total	-	-	.98
PSI Sociotropy	88.82	16.35	.90
PSI Autonomy	67.18	13.35	.85
PSI Total	-	-	.92
BSI Total	70.92	16.58	.94

Inter-rater Reliability of Vignettes

A Kappa coefficient was calculated to investigate inter-rater reliability across the four vignettes. As described in Chapter III, four expert judges rated the four vignettes across nine dimensions using a 6-point scale ranging from "not very" to "very." Raters assessed each client on dimensions of friendliness, likeability, sociability, and warmth; as well as three Likert-type questions rating the degree to which clients relayed conflicts and problems in a realistic manner, were authentic and believable, and could be imagined being seen in therapy. To ensure each

vignette accurately illustrated self-criticism or dependency issues, judges rated the degree to which each vignette portrayed the issue (self-criticism or dependency) it purported to illustrate. The overall Kappa coefficient for the four judges across the four vignettes is as follows: $K = .30$, $p < .0001$. Judges did not receive training in using this rating system and were not given specific behavioral dimensions on which to assess these qualities; therefore judges' subjectivity in rating the vignettes on these dimensions may explain the moderate Kappa coefficient for the vignettes. Separate Kappa coefficients for each dimension are presented in Table 3. Means and standard deviations for each dimension rated across the four vignettes are presented in Table 4.

Table 3

Kappa Coefficients for Judges' Ratings of Vignettes

Dimension	Kappa Coefficient
Friendliness	.08
Likeability	.14
Sociability	.22
Warmth	.08
Realistic	.05
Authentic	.15

Imaginable	.13
Illustrates Self-Criticism Issues	.41
Illustrates Dependency Issues	.44

Table 4

Means and Standard Deviations of Judges' Ratings of Vignettes

Dimension	Mean	S.D.
Friendliness	14.50	1.00
Likeability	12.50	2.52
Sociability	14.00	2.16
Warmth	14.00	1.41
Realistic	14.50	4.43
Authentic	16.50	3.32
Imaginable	16.75	3.40

DESCRIPTIONS OF VARIABLES

Below, the creation of each of the variables used in analyses is described. Means, standard deviations, and internal consistency coefficients for the independent variables are given in Table 5. Means, standard deviations, and internal consistency coefficients for dependent variables are presented in Tables 6 and 7.

Therapists' Schemas

Which of Young's early maladaptive schemata best capture the dependency and self-criticism constructs as measured by the Revised Personal Style Inventory-II?

Dependency and self-criticism schemata measures to be used as predictors in the analyses were created by combining scales from Young's Schema Questionnaire- Long Form (YSQ-L; 1990). Pearson correlation coefficients were computed among Young's 16 early maladaptive schemas (EMS) and the dependency and self-criticism subtypes assessed by the Revised Personal Style Inventory-II (PSI; Robins, Ladd, Welkowitz, Blaney, Diaz, & Kutcher, 1994). EMS subscales from the Young measure that revealed the highest correlations with the dependency and self-criticism subtypes measured by the Revised PSI-II were selected to represent therapists' dependency and self-criticism schemas. Summed raw scores of therapists' Subjugation EMS ($r = .57$, $p < .0001$) and Abandonment EMS ($r = .61$, $p < .0001$) were used to index therapists' 'Dependency Schemas'. Summed raw scores of therapists' Mistrust/Abuse EMS ($r = .59$, $p < .0001$) and Insufficient Self-Control EMS ($r = .57$, $p < .0001$) represented therapists' 'Self-Critical Schemas'. The 'Dependency Schemas' and the 'Self-Critical Schemas' are

two independent variables entered into regression models described in a later section. Means, standard deviations, and internal consistency coefficients for these independent variables are given in Table 5. Pearson correlation coefficients among therapists' Dependency Schemas, Self-Critical Schemas, and therapists' characteristics are presented in Appendix S.

Table 5

Descriptive Statistics of Independent Variables

Scale	Mean	S.D.	Alpha
Dependency Schemas	47.20	14.66	.93
Self-Criticism Schemas	56.73	15.75	.92

Therapists' Verbal Responses

As discussed in Chapter III, therapists' verbal responses were rated by expert judges using six-point Likert scales. Each response was rated on two dimensions: the extent to which the response encouraged exploration of dependency issues and the extent to which the response encouraged exploration of self-criticism issues. The 'Verbal Exploration of Dependency Content' variable was calculated by summing judges' Likert ratings that assessed the degree to which the response encouraged

exploration of dependency-oriented material. Ratings of this item were summed across the four verbal responses therapists provided during the two dependency-oriented vignettes. The same summation was completed for the 'Verbal Exploration of Self-Criticism Content' variable with emphasis on judges' ratings regarding exploration of self-criticism content across the two self-criticism vignettes.

Correlations across judges' ratings of cognitive recall responses across all four vignettes were computed and are presented in Table 8.

Therapists' Cognitive Responses

Cognitive Recall

As discussed in Chapter III, therapists' cognitive recall of schema-congruent client material was rated by expert judges on a six-point Likert scale that assessed the degree to which each recalled statement reflected dependent and self-critical presenting issues. Each cognitive recall response was rated on two dimensions: the extent to which the recalled material reflected dependency issues and the extent to which the recalled material reflected self-criticism issues. The 'Cognitive Recall of Dependency Content' variable was calculated by summing judges' Likert ratings that assessed the degree to which the recalled responses reflected dependency-oriented material. Ratings of this item were summed across the twelve recalled statements therapists provided with respect to the two dependency-oriented and two self-criticism vignettes. The same summation was completed for the 'Cognitive Recall of Self-Criticism Content' variable, with emphasis on judges ratings'

regarding self-criticism content across the two dependency and two self-criticism vignettes. Correlations across judges' ratings of cognitive recall responses across all four vignettes were computed and are presented in Table 8.

Table 6

Descriptive Statistics of Dependency Dependent Variables

Variable	Mean	S.D.	Alpha
Cognitive Recall of Dependency Content	19.66	5.17	.62
Importance of Dependency Treatment Issues	13.72	1.74	.49
Outcome/Improvement for Dependency Vignettes	15.52	3.04	.83
Total Anxiety	23.55	6.15	.87
Verbal Exploration of Dependency Content	16.58	4.62	.71
Warmth/Liking/Affection	34.90	4.94	.75

Table 7

Descriptive Statistics of Self-Criticism Dependent Variables

Variable	Mean	S.D.	Alpha
Cognitive Recall of Self-Criticism Content	19.80	4.0	.27
Importance of Self-Criticism Treatment Issues	13.92	1.85	.58
Outcome/Improvement for Self-Criticism Vignettes	15.06	2.79	.80
Total Anxiety	25.51	7.41	.92
Verbal Exploration of Self-Criticism Content	15.32	3.72	.29
Warmth/Liking/Affection	31.54	4.51	.60

Treatment Outcome/Improvement

The 'Outcome/Improvement for Dependency Vignettes' variable is the summed total of these Likert-type items across the two dependency vignettes and

the 'Outcome/Improvement for Self-Criticism Vignettes' variable is the summed total of these items across the two self-criticism vignettes.

Importance of Treatment Issues

The 'Importance of Dependency Treatment Issues' variable was calculated by summing therapists' responses that assessed the degree to which dependency-oriented issues were an important issue for therapy. These responses were summed across the two-dependency-oriented vignettes. The same summation was completed for the 'Importance of Self-Criticism Treatment Issues' variable, and items assessing the importance of self-criticism issues across the two self-criticism vignettes were summed together to form this dependent variable.

Table 8

Pearson Correlation Coefficients Across Judges for Verbal Responses and Cognitive Recall

	Rater 1			
	Verbal Responses		Cognitive Recall	
	Self-Criticism	Dependency	Self-Criticism	Dependency
Rater 2				
Self-Criticism	.10	.45	.56*	.10
Dependency	.38	.62*	-.38	.34

Note: p* < .05

Affective Responses

Total Anxiety

Therapists' responses to this item for each dependency vignette were summed with the State Anxiety Inventory-Short Form STAI-S total score for each

dependency vignette to form the 'Total Anxiety' variable for the dependency vignettes. Therapists' responses to the Likert-type items for each self-criticism vignette were summed with the STAI-S total score for each self-criticism vignette to form the 'Total Anxiety' variable for the self-criticism vignettes.

Warmth/Liking/Affection

Therapists completed several items regarding degree of warmth, liking, and affection felt toward each client presented in the vignettes. As discussed in Chapter III, therapists completed two four-point Likert-type items assessing the degree to which they felt warmth toward the client and liked the client immediately following each vignette. After presentation of all four vignettes, therapists also completed two four-point Likert-type items assessing the extent to which they disliked each client and the extent to which they felt affectionate toward each client. In addition, when rating therapists' verbal responses to clients portrayed in the vignettes, expert judges provided a rating representing the degree to which they believed the therapist liked each client presented in the vignettes. Expert judges'ratings of this variable was assessed using a six-point scale.

Summation of therapists' responses to the four Likert-type items and the expert judges' ratings of warmth/liking/affection from therapists' verbal responses formed the 'Warmth/Liking/Affection' variable for each type of vignette. These responses were summed across the two-dependency-oriented vignettes to create the 'Warmth/Liking/Affection' variable for the dependency vignettes. The same process was used to create the 'Warmth/Liking/Affection' variable for the self-criticism vignettes. Dependent variables were normally distributed, with the exception of

three: boredom, empathy, and therapists' belief the client would be difficult to work with in therapy. These three variables were not included in the analyses.

OVERVIEW OF ANALYSES PREDICTING THERAPISTS' RESPONSES

Relationships between therapists' dependency or self-critical schemata and responses to schema-congruent issues were examined using linear regression equations. The 'Dependency Schemas' and 'Self-Critical Schemas' were entered into separate regression equations as the independent variable.

To assess the role of therapists' dependency schemas in predicting countertransferential responses to schema-congruent issues, therapists' 'Dependency Schemas' were entered into the model as an independent variable. Six dependent variables were used in this analysis: Cognitive Recall of Dependency Content, Importance of Dependency Treatment Issues, Total Anxiety, Verbal Exploration of Dependency Content, Treatment Outcome/Improvement for Dependency vignettes, and Warmth/Liking/Affection. The same model was created to explore the role of therapists' self-critical schemas in predicting countertransferential responses to schema-congruent presenting issues. Therapists' 'Self-Critical Schemas' was entered into the model as an independent variable and the dependent variables for this model included: Cognitive Recall of Self-Criticism Content, Importance of Self-Criticism Treatment Issues, Total Anxiety, Verbal Exploration of Self-Criticism Content, Treatment Outcome/Improvement for Self-Criticism vignettes, and Warmth/Liking/Affection. Separate regression equations were computed for each dependent variable. Linear regression results are summarized in Table 9. Pearson

correlation coefficient among therapists' Dependency Schemas, Self-Critical Schemas and the dependent variables are presented in Appendix T.

Young's early maladaptive schemata are suggested to be positively associated with distress (c.f. Young, 1999); therefore, therapists' total score on the Brief Symptom Inventory (Marteau & Bekker, 1992) was entered into the model as a covariate. To determine whether distress also accounts for the effects of dependency or self-critical schemas on therapists' responses, the BSI total score was entered in the regression model by itself, and then as a covariate in addition to the 'Dependency or Self Criticism Schemas' independent variable. Pearson correlation coefficients among the 'Dependency Schemas', 'Self-Critical Schemas' and the BSI are presented in Table 10.

Therapists' years of personal psychotherapy and years of experience were also entered as covariates in each analysis. Each of these variables was entered as a covariate in regression models exploring either the 'Dependency Schemas' or 'Self-Critical Schemas' independent variable. These analyses were conducted to assess the role of therapists' professional experience or personal therapy experience in therapists' countertransferential responses to clients with schema-congruent presenting issues. Pearson correlation coefficient among therapists' years of professional experience, years of personal therapy, and the dependent variables are presented in Appendix U. See Appendix V and W for summary of nonsignificant results.

Although not hypothesized, regression analyses also explored if the effects of the dependent variables were specific to either, or both, therapists' dependency and self-criticism schemas. Therapists' 'Self-Critical Schemas' were entered into

another model as an independent variable, and the six variables exploring countertransferential responses to dependency-oriented issues were entered as dependent variables. In addition, therapists' 'Dependency Schemas' were entered into another model as an independent variable, and the six variables exploring countertransferential responses to self criticism-oriented issues were entered as dependent variables. Results of these analyses are presented in this chapter. Nonsignificant results of these analyses are presented in Appendix X and Appendix Y.

RESULTS OF REGRESSION ANALYSES EXPLORING THERAPISTS' VERBAL RESPONSES

It was expected that therapists' dependency schemas would predict therapists' verbal responses toward clients with dependency issues.

Analyses suggest therapists' dependency schemas predict therapists' tendency to provide verbal responses which discourage exploration of dependency-oriented presenting issues, *B* = -.37, F (1,47) = 7.48, p = .01, R square = .14. To assess the role of therapists' distress in predicting verbal responses to dependency-oriented issues, therapists' total BSI score was entered into the model alone, and the effect on the verbal response variable was also significant *B* = -.38, F (1,47) = 7.74, p = .01, R square = .14. When therapists' dependency schemas were entered into this model with therapists' level of a distress as a covariate, the effect of therapists' dependency schemas on the verbal response variable was no longer significant F (1,46) = 1.21, p = .28, R square change = .02.

To assess the role of therapists' years of experience in predicting verbal responses to dependency-oriented issues, therapists' years of experience was entered into the model alone, and the effect on the verbal response variable was not significant *B* = -.15, F (1,47) = 1.11, p = .30, R square = .02. However, when therapists' dependency schemas were entered into this model with therapists' years of experience as a covariate, the effect on the verbal response variable was significant F (1,46) = 6.49, p = .01, R square change = .12.

To assess the role of therapists' years of personal therapy in predicting verbal responses to dependency-oriented issues, therapists' years of therapy was entered into the model alone, and the effect on the verbal response variable was not significant *B* = .07, F (1,47) = .25, p = .62, R square = .01. However, when therapists' dependency schemas were entered into this model with therapists' years of therapy as a covariate, the effect of therapists' dependency schemas on the verbal response variable was significant F (1,46) = 7.1, p = .01, R square change = .13.

Additional analyses also suggest that therapists' self-criticism schemas predict therapists' tendency to provide verbal responses which discourage exploration of dependency-oriented presenting issues, *B* = - .39, F (1,47) = 8.37, p = .01, R square = .15. Therefore the effect previously attributed to therapists' dependency schemas for the verbal response variable may also be attributed to therapists' self-criticism schemas.

RESULTS OF REGRESSION ANALYSES EXPLORING THERAPISTS' COGNITIVE RECALL

It was expected that therapist's dependency schemas would predict therapists' ability to recall dependency-oriented client information.

When therapists' level of distress was not accounted for, therapists' dependency schemas predicted therapists' tendency to under recall dependency-oriented client material, *B* = -.29, F (1,44) = 4.09, p = .05, R square = .09. To assess the role of therapists' dependency schemas in predicting cognitive recall while controlling for distress, therapists' total BSI score was entered into the model alone, and the effect on the cognitive recall variable was not significant F (1,44) = 1.17, p = .31, R square = .02. When therapists' dependency schemas were entered into this model with therapists' level of a distress as a covariate, therapists' dependency schemas no longer predicted the cognitive recall variable F (1,43) = .002, p = .97, R square change = .00.

To assess the role of therapists' dependency schemas in predicting cognitive recall while controlling for experience level, therapists' years of experience was entered into the model alone, and the effect on the cognitive recall variable was not significant, F (1,44) = 1.60, p = .21, R square = .04. When therapists' dependency schemas were entered into this model with therapists' years of experience as a covariate, the effect on the cognitive recall variable was not significant F (1,43) = .99, p = .33, R square change = .02.

To assess the role of therapists' dependency schemas in predicting cognitive recall while controlling for years of personal psychotherapy, therapists' years of

therapy was entered into the model alone, and the effect on the cognitive recall variable was not significant F (1,44) = 1.11, p = .30, R square = .03. When therapists' dependency schemas were entered into this model with therapists' years of therapy as a covariate, the effect on the cognitive recall variable was not significant, F (1,43) = .72, p = .40, R square change = .02.

Results of Regression Analyses Exploring Importance of Treatment Issues

It was expected that therapists' dependency schemas would predict importance therapists place on dependency-oriented treatment goals.

It was also found that therapists' dependency schemas predict therapists' beliefs about goals for treatment. More specifically, therapists' dependency schemas predicted therapists' beliefs that dependency-oriented issues are of less importance for therapy, *B* = -.35, F (1,47) = 6.56, p = .01, R square = .12. To assess the role of therapists' distress in predicting importance therapists place on dependency-oriented treatment issues, therapists' total BSI score was entered into the model alone, and the effect on the dependency treatment issues variable was also significant *B* = -.41, F (1,47) = 9.73, p = .003, R square = .17. However, when therapists' dependency schemas were entered into this model with therapists' level of a distress as a covariate, the effect on the dependency treatment issues variable was no longer significant F (1,46) = .37, p = .55, R square change = .01.

To assess the role of therapists' years of experience in predicting importance therapists place on dependency-oriented issues, therapists' years of experience was entered into the model alone, and the effect on the dependency treatment issues variable was significant *B* = -.32, F (1,47) = 5.41, p = .02, R square = .10. When therapists' dependency schemas were entered into this model with therapists' years of experience as a covariate, the effect on the dependency treatment issues variable was significant F (1,46) = 4.87, p = .03, R square change = .09.

To assess the role of therapists' years of personal therapy in predicting importance therapists place on dependency-oriented issues, therapists' years of therapy was entered into the model alone, and the effect on dependency treatment issues variable was not significant *B* = .001, F (1,47) = .00, p = .99, R square = .000. However, when therapists' dependency schemas were entered into this model with therapists' years of therapy as a covariate, the effect on the dependency treatment issues variable was significant F (1,46) = 6.5, p = .01, R square change = .124.

It was expected that therapists' self-criticism schemas would predict importance therapists place on self-criticism-oriented treatment goals.

Therapists' self-critical schemas predicted therapists' tendency to place importance on self-criticism-oriented presenting issues, F(1,47) = 4.64, p =.04, R square = .09. To assess the role of therapists' distress in predicting importance therapists place on self-criticism-oriented treatment issues, therapists' total BSI score was entered into the model, and the effect on the self-criticism treatment issues variable was significant *B* = -.31, F (1,47) = 4.88, p = .03, R square = .09. However, when therapists' self-critical schemas were entered into this model with

therapists' level of a distress as a covariate, therapists' self-critical schemas no longer predicted the treatment issues variable F (1,46) = .79, p = .38, R square change = .02.

To assess the role of therapists' years of personal therapy in predicting the importance therapists place on self-criticism-oriented issues, therapists' years of therapy was entered into the model alone, and the effect on self-criticism treatment issues variable was not significant *B* = .15, F (1,47) = 1.1, p = .31, R square = .02. However, when therapists' self-criticism schemas were entered into this model with therapists' years of therapy as a covariate, the effect on self-criticism treatment issues variable was significant F (1,46) = 4.78, p = .03, R square change = .09.

To assess the role of therapists' years of experience in predicting importance therapists place on self-criticism oriented issues, therapists' years of experience was entered into the model alone, and the effect on the self-criticism treatment issues variable was not significant *B* = -.18, F (1,47) = 1.6, p = .21, R square = .03. When therapists' self-criticism schemas were entered into this model with therapists' years of experience as a covariate, the effect on the self-criticism treatment issues variable was not significant F (1,46) = 3.10, p = .09, R square change = .06.

Table 9

Summary of Results for Linear Regression Analyses for Dependency Schemata Predicting Therapists' Countertransferential Responses to Dependency Vignettes (N=50)

Dependent Variable	R Square	F	B	SEB	*B*
Cognitive Recall of Dependency Content	.09	4.09	-.10	.05	-.29*
Verbal Exploration of Dependency Content	.14	7.48	-.11	.04	-.37*
Importance of Dependency Treatment Issues	.12	6.56	-.02	.01	-.35*

Note: *p < .05

Table 10

Pearson Correlation Coefficient among Therapists' 'Dependency Schemas', 'Self Critical Schemas' and BSI Total Score

Variable	Dependency Schemas	Self-Criticism Schemas	BSI Total Score
Dependency Schemas	1.0	.75**	.71**
Self-Criticism Schemas	.75**	1.0	.68**
BSI Total Score	.71**	.68**	1.0

Note: **p < .01

THERAPISTS' SELF-REPORTED ORIGINS OF DEPENDENCY AND SELF-CRITICISM SCHEMATA

This study attempted to explore therapists' early maladaptive schemata, or schemas which form as a result of experiences with attachment figures or peers in early life (Young, 1990). It is possible that therapists' dependency and self-criticism schemata form as a result of life or training experiences, separate from early life

experiences proposed by Young's model. To provide some clarification surrounding this issue, therapists were asked to speculate about life or training experiences which influence how they focus on dependency and self-criticism issues in therapy. This data was collected during brief one-on-one interviews with each participant at the conclusion of the study. The investigator reviewed this data for common themes across participants and was not explored using quantitative analyses. Examples of therapists' responses are presented in Table 11.

Therapists reported several factors influence their work related to dependency issues. Consistent with Young's explanation of early maladaptive schemata (1990), 68% of participants reported that relationships with friends, fellow graduate students, and family informed how they approach interpersonal issues with clients. Therapists also stated that successes and failures in their own relationships, as well as poor communication and lack of connectedness in their family of origin, has influenced their style of addressing dependency issues in therapy. Eight percent of therapists identified spirituality or religious background as another factor which influences their style of addressing dependency issues. Therapists also reported that several types of training experiences influence how they explore dependency issues, and 48% of therapists cited their own psychotherapy, supervisory relationships, research, coursework, and clinical experiences as important factors. Twenty-two percent of therapists identified theoretical perspectives as influential in addressing interpersonal or dependency issues, such as psychodynamic theory, object relations, interpersonal theories of depression, attachment theory, models of disconnection, the self-in-relation model, family systems perspectives, and self-psychology.

Therapists identified several factors which influence their style of addressing self-criticism or achievement issues with clients. Forty-four percent of therapists reported their parents' emphasizing achievement throughout their upbringing and modeling achievement-oriented behavior was a major influence in how they address achievement or self-criticism issues in therapy. Some of these respondents also stated that their parents' lack of achievement-oriented pressure, and focus on learning as opposed to attaining goals, has influenced their perceptions of achievement-oriented presenting issues. Parental messages to be independent and self-supporting were also cited by several therapists. Eight percent of therapists stated that goal-oriented therapy approaches or cognitive-behavioral interventions have influenced their approach to achievement or self-criticism issues in therapy. Thirty-eight percent of therapists reported that personal experience in graduate school, determining a career focus, and exposure to other goal-directed individuals influenced how they conceptualize and address self-criticism or achievement-oriented issues with clients.

Therapists reported several experiences influence how they address dependency or self-criticism issues in therapy, many of which originate from therapists' own experiences in childhood, which is consistent with the definition of early maladaptive schemata (Young, 1990) explored in this study. It also appears several other factors influence therapists' conceptualization and approach to addressing dependency and self-criticism issues. Therapists' training experiences, professional development, and respective theoretical orientations appear to play some role in schema development beyond the origination of the early maladaptive schemata in childhood. In interpreting the findings of this study, it is important to

consider various factors (e.g. educational, professional) that contribute to therapists' development of dependency and self-criticism schemata, and how these sources contribute to therapists' approach toward these issues in therapy.

Table 11

Examples of Therapists' Self-Reported Origins of Dependency and Self-Criticism Schemata

Interpersonal/Dependency
"My own therapy and messages from my family of origin that people are the most important things in life, to value people."
"My own interest in attachment, how relationships with caregivers inform current relationships, so this guides how I look at these things in therapy with clients."
"I've had really healthy interpersonal relationships and they have been templates for what healthy relationships can be."
"Being a T.A. for theories courses, watching tapes, and talking with supervisors."
"My practicum emphasized forming relationships with clients and them knowing you will not break their trust."
Self-Criticism/Achievement
"My parents have never given me pressure, so I feel relaxed, have no agenda when working with clients on those things."

"My personal family experience, notion that you can define your own…whatever you are supposed to do in the world, and I was told you can achieve whatever it is you want to, and I worked hard for that."

"Cognitive orientation, working with high goal-oriented people in program influenced me."

CHAPTER 5:

Discussion

Overview and Discussion of Findings

The results of this dissertation support theoretical claims of cognitive and countertransference researchers that therapists' self-schemata predict countertransferential reactions characterized by avoidance or distancing from emotionally evocative material in therapy. Avoidant countertransferential behaviors appear to manifest on a variety of cognitive and behavioral levels, including therapists' verbal responses, memory for client material, and perceptions of issues central to therapy.

Specifically, results of this study suggest therapists' dependency schemata are associated with therapists' tendency to provide verbal responses to clients that avoid or discourage exploration of dependency-oriented problems. Difficulty remembering dependency-oriented material was also associated with therapists'

dependency self-schemata. However when therapists' level of distress was held constant, dependency schemas no longer predicted a tendency to avoid verbal exploration of dependency-oriented issues. This finding is especially noteworthy as it suggests some combination of distress and dependency schemas predict these specific types of countertransferential responses, or that therapists' level of distress plays a larger role in facilitating countertransferential reactions than expected.

In addition, therapists' dependency schemas were also related to therapists' tendency to view dependency-oriented problems as less central to treatment and when therapists' level of distress was held constant, therapists' dependency schemas no longer predicted this response. Again, it appears therapists' distress plays an important role in manifesting countertransferential reactions to schema-congruent material. Therapists' years of professional experience and personal therapy were also controlled for in these analyses, and these results suggest therapists manifest countertransferential reactions to schema-congruent material irrespective of their professional or personal experience in therapy

The majority of analyses exploring therapists' self-criticism schemata and countertransferential reactions did not yield significant results, which might reflect underlying problems with the autonomy/self-criticism construct suggested in previous studies of this personality type.

Early Maladaptive Schemata Associated with Dependency

The present results suggest Young's Subjugation and Self-Sacrifice EMS best capture the dependency subtype. Young's descriptions of these schemata are

conceptually consistent with explanations of dependency by previous researchers (c.f. Arieti & Bemporad, 1980: Beck, 1983; Blatt et al., 1983). For example, Young describes the Subjugation EMS as "E]xcessive surrendering of control to others because one feels coerced-usually to avoid anger, retaliation, or abandonment" (1999, p.15). Young identifies two major forms of subjugation, "subjugation of needs" or repression of one's preferences or wishes, and "subjugation of emotions" or withholding expression of feeling (1999, p.15).

Young describes the Self-Sacrifice EMS as "E]xcessive focus on voluntarily meeting the needs of others in daily situations, at the expense of one's own gratification" and states that "T]he most common reasons are to prevent causing pain to others, to avoid guilt from feeling selfish, or to maintain the connection with others perceived as needy" (1999, p.15). Definitions of the dependency subtype, on which this study is based, have several conceptual similarities to the Subjugation and Self-Sacrifice EMS conceived by Young (1990). However it is also important to note that other EMS have conceptual similarities with the dependency personality style, such as Dependence/Incompetence, Abandonment, and Enmeshment EMS. Again, it is important to emphasize that associations between Self-Sacrifice and Subjugation EMS and dependency may be idiosyncratic to therapist populations or the therapists in this particular sample, therefore the generalizability of these findings may be limited.

Early Maladaptive Schemata Associated with Self-Criticism

The self-criticism construct was most associated with Young's Mistrust/Abuse and Insufficient Self-Control EMS. Young defines the Mistrust/Abuse EMS as "T]he expectation that others will hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage. Usually involves the perception that the harm is intentional or the result of unjustified and extreme negligence." Young also states that the Mistrust/Abuse EMS "M]ay include the sense that one always ends up being cheated relative to others or gets the short end of the stick" (1999, p. 12). Conceptual similarities between Young's Mistrust/Abuse EMS and the self-critical construct are not immediately apparent, yet previous studies (e.g., Crosby-Ouimette, et al, 1994) suggest self-criticism measured by the PSI is highly associated with paranoid behavior. This relationship may explain associations between the Mistrust/Abuse EMS and self-criticism subtype found in this study. Several studies conducted by Zuroff and colleagues explored relationships between self-criticism and interpersonal processes, and offer some support for the conceptual overlap between the Mistrust/Abuse EMS and autonomy. For example, in their study on attachment style in college students, Zuroff and Fitzpatrick (1995) suggested self-criticism is associated with a fearful-avoidant attachment style. In another study examining autonomy and interpersonal relationships in college students, Zuroff, Stotland, Sweetman, Craig, and Koestner (1995) conclude "self-criticism has been associated with the avoidance of emotionally intimate relationships and with remaining distrustful, non-self-disclosing, and dissatisfied within those relationships that are established" (p. 544). It appears that highly self-critical individuals may

avoid interpersonal relationships out of fear of being hurt or treated unfairly by others and Young's Mistrust/Abuse EMS may capture this specific aspect of the self-criticism construct.

Young's Insufficient Self-Control EMS was also associated with self-criticism as measured by the PSI-II. Young defines this EMS as "P]ervasive difficulty or refusal to exercise sufficient self-control and frustration tolerance to achieve one's personal goals, or to restrain the excessive expression of one's emotions and impulses" (1999, p.14). Associations between the Insufficient Self-Control EMS and self-criticism may be explained by the tendency of those with a self-critical personality type to have a harsh view towards his/her ability to obtain goals or aspirations. In other words, self-critical individuals may develop a harsh or restricted view toward their ability to exert control over obtaining personal achievement, which may explain the relationship between the autonomy construct and the Insufficient Self-Control EMS. Young (1990) also describes individuals with Insufficient Self-Control EMS as having low frustration tolerance for obstacles while meeting personal goals, and these individuals' excessively self-critical style may parallel the low frustration tolerance described by Young. That is, a self-critical style may incite low frustration tolerance for minor set backs or failures.

Definitions of the self-criticism subtype have several conceptual similarities to the Mistrust/Abuse and Insufficient Self-Control EMS proposed by Young (1990), however it is important to note that other EMS appear to have conceptual similarities with the self-critical personality style. Definitions of EMS such as the Defectiveness/Shame, Social Isolation, or Unrelenting Standards EMS appear to have strong conceptual similarities to the self-criticism construct as well. Again, it is

important to emphasize that associations between the Mistrust/Abuse and Insufficient Self-Control EMS and self-criticism may be idiosyncratic to therapist populations or the therapists in this particular sample, therefore these findings must be interpreted with caution.

Though several of Young's EMS have conceptual similarities with the dependency and self-criticism dimensions as measured by the PSI-II, and these measures were used to represent schemata in this study, there are limitations in measuring schemas via self-report measures. These limitations are addressed in a later section. In addition, associations between Young's EMS and the dependency and self-criticism dimensions assessed by the PSI-II are based on responses of a relatively homogenous sample (high-educated, Caucasian female therapists in their twenties and thirties), therefore these findings should be interpreted with caution.

Role of Therapists' Dependency Schemas in Predicting Verbal Responses

In the present study, therapists' dependency schemata predicted the degree to which therapists provided verbal responses that discouraged or avoided exploration of dependency-oriented issues. It appears therapists' dependency schemata may be vulnerable to activation when confronted with clients' schema-congruent presenting issues, and might facilitate therapists' use of language that prevents exploration of material which is emotionally evocative for the therapist. Therapists' verbal avoidance behavior in this study is consistent with other studies of countertransference behavior, which also revealed relationships between therapists' avoidant verbal behavior and therapists' discomfort with presenting issues (c.f. Gelso, et al., 1995; Hayes & Gelso, 1993).

An opposing perspective surrounding this issue is that individuals interpret incoming stimuli in a way that is consistent or maintains their self-schema, however the therapy relationship may be unique in that it elicits behavior unconsciously designed to avoid or prevent activation of therapists' schemas. Young (1990) has developed a language for understanding how non-volitional or automatic processes help individuals either maintain or avoid activation of self-schemata, and his descriptions have several conceptual similarities with the way in which therapists responded in this study. For example, therapists' verbal responses to schema-congruent material in the present study might represent attempts at "behavior avoidance" (1999, p.23) as therapists are altering behavior to avoid "real-life situations or circumstances that might trigger painful schemas." If therapists were to approach or explore the dependency-oriented issue, they may be vulnerable to schema activation and distress that may be associated with that schema.

It is important to consider that this finding is not based on "real-life situations or circumstances" (1999, p. 23) described by Young as therapists in this study were responding to audio taped vignettes as opposed to actual clients. This is one limitation of this study which is explored in a later section, however these results suggest therapists with dependency schemata are less likely to discuss similar issues with clients. An implication of this finding is that therapists' dependency schemata may influence the extent to which therapists allow exploration of dependency-oriented topics, which might prevent focus on those immediate needs and concerns of the client.

These findings should also be examined in light of the largely female sample in this study. Recent investigations of countertransferential behavior have explored

gender differences in therapists' under or over-involvement with clients, and suggest females' countertransferential reactions are demonstrated through over-involvement with clients (c.f. Hayes, McCracken, McClanahan, Hill, Harp, & Carozzoni, 1998; Rosenberger & Hayes, in press). These findings are inconsistent with results of the present study as this investigation revealed that a largely female sample of therapists manifest countertransference as under as opposed to over-involvement with clients' issues. This inconsistency may be explained by the focus on the dependent personality style in this research. Perhaps the countertransference-producing material in question determines over/under-involvement countertransferential behaviors, and types of reactions may occur as a function of gender.

Countertransference researchers have also found evidence of positive relationships between therapists' avoidant countertransferential behavior and anxiety, however results of this study do not support this claim. While therapists in this study demonstrated avoidant verbal responses when confronted with dependency-oriented issues, therapists did not report feeling anxious when confronted with schema-congruent presenting issues. Though schema-congruent issues did not elicit anxiety from therapists, therapists' distress measured at the time of the study appears to play an important role in therapists' responses to dependency-oriented issues. Interestingly, therapists' overall self-reported distress appears to play a role in manifestation of countertransferential responses, whereas therapists' anxiety in response to schema-congruent issues was not detected in this study. The role of therapists' distress will be discussed in a later section.

Lack of findings regarding therapists' anxiety may be due to the analogue nature of this study as therapists may have experienced listening to audio taped vignettes as less emotionally invasive than being in the presence of an actual client. Other studies that have found evidence of affective countertranferential responses used video as opposed to audio taped presentations of clients. These studies were also analogue; therefore it is possible that visual information provided in videotape or actual therapy sessions explains the affective response not detected in the present study. It is also possible that the types of constructs explored, dependency and self-criticism, do not elicit the anxiety response from constructs explored in previous studies, such as homophobia and death anxiety (c.f. Gelso, et al, 1995; Hayes & Gelso, 1993).

Comparisons between Therapists' Dependency and Self-Criticism Schemas in Predicting Verbal Responses

The present study failed to detect any relationship between therapists' self-criticism schemata and verbal responses to clients with self-criticism presenting issues. It might be that therapists with self-criticism schemata are better able to manage countertransferential responses to self-critical presenting issues as self-criticism may be experienced more consciously and processed internally. In contrast, therapists' dependency self-schemata may be more readily available in the context of an interpersonal relationship, and are therefore less easily managed and more likely to predict countertransferential behavior.

As discussed in the previous section, it is possible that the conflictual material in question determines the nature of a countertransferential response. That

is, one type of personality style or construct may elicit approach-oriented behavior, whereas another construct may invite avoidant-oriented countertransferential behavior.

It also appears the autonomy/self-criticism construct has been susceptible to a variety of measurement problems in previous studies, therefore the lack of findings related to self-criticism in this study may also be explained by the apparent complexities in measuring this construct. Problems surrounding measurement of the autonomy/self-criticism construct will be explored in greater depth in a later section.

Role of Therapists' Dependency and Self-Criticism Schemas in Predicting Cognitive Recall

Another type of countertransferential behavior explored in this study was cognitive recall of therapy content congruent with therapists' self-schemata. This study suggests therapists' schemata predict therapists' tendency to under-recall schema-congruent client information. Therapists' tendency to under-recall schema-congruent material in this study is consistent with other studies of countertransference behavior, which also revealed relationships between therapists' avoidant verbal behavior and therapists' discomfort with presenting issues (c.f. Gelso, et al., 1995; Hayes & Gelso, 1993).

This study is also one of few known studies of cognitive manifestations of countertransference that explore distortion of content, as opposed to distortion of clients' behaviors or accurate recall of clients' words. Previous studies (c.f. Gelso, Fassinger, Gomez, & Latts, 1995; Hayes & Gelso, 1993) explored therapists' accuracy in recalling actual material from therapy sessions, or therapists' under or

over- recalling clients' behaviors in therapy that are consistent with therapists' unresolved conflicts (Cutler, 1958). In contrast to exploring distortion of behaviors or clients' words, this study explored distortion of content and supports the notion that therapists' schemas predict the degree to which they under-recall schema-congruent content from clients presenting with dependency issues.

This finding is also consistent with Young's schema avoidance concept described earlier as therapists may under-recall schema-congruent information in attempt to escape information that triggers their own self-schemata (Young, 1999). Remembering schema-congruent material might lead to therapists' own schemata to become activated and elicit emotional discomfort. This type of avoidance closely represents "cognitive avoidance" described by Young (1999, p.23) as under recall of schema-congruent material may represent an "automatic or volitional attempt(s) to block thoughts or images that might trigger the schema."

Role of Therapists' Dependency and Self-Criticism Schemas in Predicting Importance Placed on Schema-Congruent Treatment Issues

In addition to exploring cognitive recall for schema-congruent information, this study explored other cognitive manifestations of countertransference, such as importance therapists place on schema-congruent treatment goals. Traditionally, studies of cognitive manifestations of countertransference have focused on therapists' cognitive recall for therapy events and processes, but more recent studies are examining thought processes of therapists as countertransferential reactions to clients. Hayes and Gelso (2001) emphasize the importance of countertransference research taking this direction as therapists' decision-making surrounding treatment

may be influenced by these thought processes, which in turn, might be harmful to clients' experience in therapy. This study represents one attempt to explore cognitive manifestations of countertransference outside the realm of cognitive recall.

In this study, therapists' dependency schemata predicted the extent to which therapists believe clients should focus on dependency-oriented issues in treatment. Specifically, therapists' dependency schemas predicted therapists' belief that dependency-oriented issues are less central to clients' treatment. This finding is in line with Young's notion of "cognitive avoidance" (1999, p. 23) described in earlier sections, and represents therapists' bias against exploration of issues which might lead to schema activation and corresponding emotional discomfort. An implication of this finding is that therapists' dependency schemata may determine the extent to which therapists guide clients toward treatment goals that are less emotionally evocative for therapists, a process which might deter exploration of clients' needs or concerns.

Role of Distress in Cognitive and Behavioral Manifestations of Countertransference

It has been widely suggested that psychological distress accompanies schema-activation (c.f. Segal, 1988; Young, 1999) and many countertransference theorists (c.f. Hayes & Gelso, 2001) also suggest heightened affect is closely tied to countertransferential behavior. Therefore distress likely plays an important role in schema activation and corresponding countertransferential behaviors.

In this study, therapists' distress appeared to play a crucial role in therapists' countertransferential reactions to schema congruent material. In analyses exploring

the role of distress in therapists' verbal responses and importance placed on schema-congruent treatment issues, distress appears to drive the relationship between therapists' schemas and the countertransferential response in question. This finding is especially intriguing as it supports theoretical assertions of countertransference and schema theorists that distress is closely tied to schema activation, as well as the manifestation of countertransferential behaviors.

It is also interesting to reflect on the types of countertransferential responses which appear most vulnerable to therapists' distress. Whereas therapists' schemas and distress predict therapists' countertransference related to verbal responses and importance placed on treatment goals, therapists' schemas and distress did not have the same influence on other indices of therapists' countertransferential responses. Perhaps the type of countertransferential response in question (e.g. verbal, cognitive recall, anxiety) determines the degree to which distress plays a role in this process

Therapists' distress did not appear to influence relationships between therapists' self-criticism schemata and responses to schema-congruent issues. As explored previously, it might be that the type of countertransferential behavior in question determines the extent to which therapists' distress plays a role, or that the conflictual material in question differentially influences the resulting countertransferential response.

Role of Therapists' Experience and Personal Psychotherapy in Predicting Countertransferential Responses

Another aim of this study was to explore the role of therapists' years of experience and personal psychotherapy in predicting countertransferential responses

to clients with schema-congruent presenting issues. Several of the analyses in this study, such as those exploring verbal responses and importance placed on schema-congruent treatment goals, suggest therapists' years of experience and personal therapy do not contribute to these types countertransferential responses. Interestingly, therapists appear to manifest countertransferential reactions to schema-congruent material irrespective of their professional or personal experience in therapy. This finding supports schema theorists' assertion that self-schemas are rigid and persistent (Young, 1990) in that therapists' schemas predicted responses to schema-congruent material irrespective of these factors. Though this finding is noteworthy in that it suggests countertransferential responses occur irrespective of these factors, this finding should be interpreted with caution as the range of professional experience and personal therapy experience of this sample was somewhat restricted.

Problems in Measurement of Autonomy/Self-Criticism

The majority of results in this study revealed findings in regards to the dependency construct, and lack of findings surrounding the self-criticism construct is likely due to various problems surrounding measurement of this personality type. Problems in measuring the self-criticism construct is consistent with several other investigations of this personality type (c.f. Rude & Burnham, 1993), and it appears there is some agreement among researchers that the self-criticism construct is a less tight, more elusive construct to capture and measure than its dependency counterpart.

While Young's EMS (1990) appear to be conceptually associated with the self-criticism sub scale of the PSI, therapists in this study failed to respond to this construct over a variety of measures. There also appears to be measurement problems surrounding the self-criticism construct in this study as alpha levels for this dependent variable were significantly low for both the cognitive recall and verbal response self-criticism variables. In addition, expert coders demonstrated significantly less agreement in coding verbal responses for self-critical as opposed to dependency verbal exploration.

The construct also appears to be composed of two separate properties, autonomy and self-criticism, which might have caused some confusion in creating the stimulus materials (e.g., vignettes) and measurement procedures (e.g. coding of verbal responses and cognitive recall) for this study. In representing both the autonomy and self-critical components of this construct, it is possible that content validity and authenticity of the vignettes was compromised. It is also possible that coding of verbal responses and cognitive recall content was difficult for coders to perform with accuracy as they were asked to rate the extent to which the data represented one construct along a continuum, whereas the continuum actually reflected more than one construct. Therefore, the seemingly fragmented nature of the autonomy/self-criticism construct may be one reason for the lack of significant findings in this area.

Another reason for the lack of significant findings surrounding the self-critical construct may be therapists' reactions to the two self-critical vignettes in this study. At the conclusion of the experiment several therapists commented that the clients in the self-critical vignettes were especially irritating and unlikable. Though

these clients were judged by expert raters to be somewhat commensurate on different dimensions prior to data collection, it is possible that the presentation of these particular client types and therapists' negative reactions to these vignettes influenced their responses on the various self-critical dependent measures.

Another critique that deserves mention involves social value and meaning ascribed to the self-criticism and dependency constructs. Western culture attaches significant importance to independence and personal fulfillment, whereas nonwestern culture emphasizes interdependence and responsibility for others' well-being. For example, in their comparison of Japanese and American culture, Minatoya & Higa (1988) state "W]hereas Americans cherish independence and autonomous rights, the Japanese prize interdependence and obligation toward others" (Minatoya & Higa 1988; as cited in Baruth & Manning, 1999). Because autonomy and self-fulfillment is a core assumption of numerous western ideals and belief systems, dependent behavior or a more interdependent world view is often pathologized by western culture. And given that the latter worldview is often thought to be more characteristic of females in western culture, females might be more vulnerable to rejection accompanying a more interdependent worldview. In interpreting the results and implications of this dissertation, it is important to consider the conceptual underpinnings of the self-criticism and dependency constructs, and how socially constructed meanings and values of these constructs might be conceptualized within a therapeutic setting.

GENERAL LIMITATIONS OF THE PRESENT STUDY

Limitations of Instruments

Because this study heavily relied on self-report measures to determine therapists' self-schemata, it is important to mention limitations of assessing schemata using self-report instruments. In discussing approaches to measuring self-schemata in depression, Segal states self-report measures capture only "evidence for a descriptive definition of a schema" (1988, p. 152). He goes on to suggest that self-report measures assess merely attitudes or beliefs representative of the schema, and do not capture the complex nonconscious aspects of self-schemata. Segal's criticism of self-report measures highlights the importance for schema researchers to consider more innovative measurement techniques to best capture the nonconscious and automatic aspects of self-schemas.

In effort to address concerns raised by Segal and others regarding measurement of self-schemata using paper-pencil measures, some schema theorists have begun to utilize more complex approaches to measuring underlying cognitive structures, and have explored the usefulness of self-report measures in measuring self-schemas. For example, Rude, Covich, Jarold, Hedlund, and Zentner (2001) examined the utility of questionnaires verses laboratory tasks in detecting schemata in depression vulnerable individuals. Another study detected dependency or self-critical schemata by asking participants questions designed to elicit specific examples of achievement or interpersonally oriented events occurring within the past month. Hammen, Marks, Mayol, and deMayo (1985) based this measurement

approach on the notion that recall for schema-congruent events would be higher than schema-incongruent events. A limitation of this study is its reliance on self-report measures to assess therapists' dependency or self-criticism schemata, and criticism of this measurement technique would suggest that therapists' beliefs and attitudes were assessed as opposed to dependency or self-criticism self-schemata central to this study.

Another limitation of this study involves measurement of therapists' distress. Following the vignette procedure, all therapists completed the BSI so that level of distress may be controlled in examining therapists' countertransferential reactions. Though this was the intended purpose of the BSI, it is possible that the BSI actually assessed therapists' anxiety in response to the procedure, specifically, performing on audiotape. Therefore the true source of therapists' distress in this study remains ambiguous as the sample's distress may be attributed to affect tied to schema activation, countertransferential feelings precipitating countertransferential behaviors, represent distress related to the performance-nature of the experiment, or may indicate distress due to factors unrelated to this experiment. While the source of therapists' distress may not be clarified in the present study and represents one of its limitations, these questions highlight an important area for future research.

It also important to mention that only moderate interrater agreement was calculated for the audiotaped case vignettes. As mentioned in a previous section, judges did not receive training in using a specific rating system and were not given specific behavioral dimensions on which to assess clients' qualities; therefore judges' subjectivity in rating the vignettes may explain their moderate interrater

agreement. Additionally, judges' ratings of therapists' cognitive recall and verbal responses demonstrated only modest agreement in some categories.

Limitations of the Procedure

Two limitations of the vignette portion of the procedure deserve mention. In providing verbal responses to each vignette, several participants commented that they experienced anxiety as a function of performing on audiotape, as opposed to experiencing anxiety in response to the actual vignette. Therefore, it is possible that therapists' state anxiety in response to the verbal response procedure artificially inflated therapists' affective arousal in response to the vignettes.

Another limitation of the vignette portion of the study involves therapists' verbal responses to each client portrayed in the vignettes. Therapists were given two pre-determined response intervals for each vignette, allowing two samples of verbal behavior to be recorded in response to each personality type. Though this measurement approach provided a controlled means by which to collect therapists' verbal responses, it should be noted that therapists experienced this aspect of the procedure as somewhat forced and artificial. It is likely that therapists' verbal responses to actual clients would differ in frequency and duration to those responses collected during this study. In addition, though therapists were told by the investigator that he or she may be silent during the response times, the procedure seemed to force verbal responses from therapists who might have, under less artificial circumstances, offered no verbal response.

Another limitation to this study is the lack of visual or nonverbal information therapists were given about clients presented in the vignettes. Because each client

was presented via written and audio means only, clients' physical attributes and nonverbal cues were not available sources of information for therapists. Had therapists been exposed to a visual representation of the client, such as videotape, therapists' countertransferential reactions may have been different from those reactions detected in the present study. This is an important point to consider in interpreting these findings as countertransferential reactions in this study were measured in response to written and auditory means only. These limitations, as well as those mentioned previously, emphasize many of the drawbacks in conducting analog research.

Limitations of the Sample

Another limitation of this study that deserves mention is the homogeneity of its sample. Eighty percent of participants were female and eighty percent of participants were Caucasian, therefore results for this study should be interpreted conservatively with diverse populations. The preponderance of graduate students in the sample and limited individual therapy experience may also confound this study. Ninety-percent of participants in this study were working toward a graduate degree in a mental health-related field during data collection, and fifty-eight percent of the sample had one to three years of individual therapy experience. Therefore, level of expertise within this sample may have served as a confound to the findings of this study. For example, Friedman and Gelso (2000, p.1231) state "Inexperience may be a factor that triggers unresolved feelings of inadequacy or a desire to please. Thus, befriending a client, talking too much, or providing too much structure in a session indeed may reflect underlying therapist conflicts." Some countertransference

researchers (c.f. Friedman & Gelso, 2000) have also suggested that therapists with less experience display greater anxiety than more experienced therapists. If this pattern in novice therapists exists, then fluctuations in therapists' countertranferential responses in this study may be explained by inexperience as opposed to therapists' self-schemata.

IMPLICATIONS AND DIRECTIONS FOR FUTURE RESEARCH

Implications for Clinical Practice

In view of these results, therapists' dependency schemata appear to influence therapists' verbal responses, recall for dependency-oriented information, and beliefs surrounding clients' treatment goals. Because therapists' dependency schemas predict cognitive and behavioral responses toward clients with dependency issues and there is some evidence that unacknowledged countertransferential feelings are linked to harmful countertransferential behaviors, it is important for therapists to maintain awareness and insight into these particular schemas. It is also useful for therapists to consider the range of countertransferential behaviors which may occur in response to clients with schema-congruent presenting issues.

Another implication of these findings is that therapists' countertransferential responses, such as an inability to recall schema-congruent client material, might negatively effect therapy over time. It is conceivable that therapists' ineffectiveness in remembering client material across sessions might hinder several aspects of the

therapeutic process, such as therapists' ability to conceptualize clients' presenting concerns and establish rapport with clients. Therefore it appears that while under-recall of schema congruent client material acts as a protective mechanism for the therapist in therapy, a pattern of under recall across sessions might hinder the progress of treatment. In a similar vein, therapists' tendency to avoid verbal exploration of schema-congruent presenting issues and place less emphasis on schema-related treatment goals may also negatively impact the therapeutic relationship and fail to serve those needs most salient to the client.

Hayes and Gelso (2001) suggest therapists' knowledge of their own unresolved issues and some degree of mastery over these issues promotes regulation of countertransferential behaviors. The former is also emphasized in Greenwald and Young's description of supervision for Schema-Focused Cognitive Therapy (SFCT, 1998). In describing eight experiences central to SFCT supervision, the authors suggest supervisees explore his/her own early maladaptive schemas and become aware of early maladaptive schemas which might become activated and impede progress in therapy. These studies, in conjunction with findings of this dissertation, underscore the importance of therapists' identifying their own self-schemas and exploring factors that might facilitate their activation in therapy.

In terms of clinical supervision, supervisors and supervisees may explore supervisees' experiences with clients from a different perspective. In processing supervisees' verbal responses to clients' dependency oriented issues or exploring supervisees' perceptions about clients' treatment goals, supervision may attend more fully to the role of supervisees' dependency schemas in viewing these aspects of therapy. Considering that therapists' dependency schemas appear to play some role

in their behavioral and cognitive reactions to clients with dependency issues, it might be interesting and enriching for supervisors to conceptualize supervisees' reactions to clients in terms of schema activation and schema maintenance processes (Young 1999) when appropriate.

In light of results regarding therapists' tendency to place less importance on schema-congruent treatment goals, supervisees may avoid seeking supervision regarding their work with clients when clients' presenting concerns are consistent with therapists' self-schemas. It is also possible that supervisors' own schemas influence their tendency to discourage or avoid supervisess' exploration of certain clients and/or personality types.

Implications for Research

While this dissertation possesses potential contributions to several existing areas of literature, it also combines cognitive theory, countertransference literature, and dependency/self-critical personality theory in a manner that has not been previously conceptualized. In addition, this study represents one of the first known attempts to explore countertransference from a schema-theory perspective and will hopefully set groundwork for future examinations of countertransference or schema activation in therapy contexts. This dissertation also offers some empirical support for the importance of therapists' exploration of their own self-schemas in therapy and supervision contexts.

This dissertation also introduces another exploration of the dependency and self-criticism sub types beyond the scope of depression, and might incite further

research surrounding these personality types in therapists and their role in therapists' efficacy and treatment outcome. Problems surrounding measurement of the self-critical sub type in this study might also raise awareness surrounding measurement issues of this particular construct, and the possibility that this construct is a less homogenous construct than its dependency counterpart.

Future Research of Early Maladaptive Schemas and Dependency/Self-Criticism Subtypes

This study suggests Young's Subjugation and Self-Sacrifice early maladaptive schemata best represent the dependency construct measured by the PSI-II, and that Mistrust/Abuse and Insufficient Self-Control EMS best represent the self-critical construct measured by the PSI-II. While these EMS were used to represent dependency and self-criticism schemas in this study, it is important to emphasize that associations between these EMS and the dependency/self-critical sub types may be specific to this particular sample. Therefore future research may explore associations between Young's EMS and the self-critical/dependency constructs in a less homogenous sample.

In addition, several other EMS described by Young (1990) appear to have their own conceptual similarities with these constructs.. For example, definitions of EMS such as the Defectiveness/Shame, Social Isolation, or Unrelenting Standards EMS appear to have strong conceptual similarities to the self-criticism construct, and Young's Abandonment, Dependence/Incompetence, and Enmeshment EMS have conceptual similarities with the dependency construct. Therefore, future research may also focus on any subtle differences between Young's EMS, and what

factors determine their individual associations with the dependency and self-criticism constructs

Future examinations of therapists' schemata might also use more innovative measurement techniques, such as those used by Hammen, et al (1985), to provide a more sensitive and accurate measure of therapists' schemata. As discussed in a previous section, self-report measures may not capture the more complex nonconscious aspects of self-schemata; therefore information processing measures or approaches beyond self-report measures may offer a more accurate representation of therapists' self-schemas.

Future Research of Countertransferential Reactions to Dependency-Oriented Issues

Countertransferential reactions may occur as a function of therapy content or therapy processes. While this study explored therapists' countertransferential reactions to therapy content or material presented in therapy by clients (Hayes & Gelso, 2001), future research may explore therapy process or "how the therapist and client talk…what transpires between them, and what happens to them" (2001, p.1044). Because dependency-oriented issues might be played out within the therapeutic relationship, future research might explore the role of therapists' dependency schemas in predicting countertransferential reactions to therapy process as opposed to therapy content. This research would also expand early studies (c.f. Schuldt, 1966), which explore countertransference responses to dependency issues represented during therapy process.

Future research may also explore implications of managing verses mismanaging countertransferential reactions to dependency-oriented issues. Traditionally, therapists and countertransference researchers have emphasized the importance of managing countertransference reactions and not using countertransference reactions as interventions. More recently, researchers are considering the possibility that some "therapeutically optimal level of countertransference" (Hayes & Gelso, 2001, p.1047) does exist, and suggest future research may explore conditions in which clients might benefit from therapists' disclosure of countertransferential reactions in session. Therefore future research might also explore consequences (e.g., treatment outcome, quality of therapeutic relationship) of therapists' containing or not containing countertransferential reactions in response to dependency-oriented presenting issues.

Future investigations surrounding countertransferential reactions to dependency-oriented issues might also access a more heterogeneous sample than that used in this dissertation. This sample was mostly comprised of Caucasian females in their twenties and thirties, most of whom had comparable clinical experience and were trained in the same graduate program. Therefore it would be important for future research to explore countertransferential reactions to dependency-oriented issues in a sample that was significantly more varied in terms of gender, ethnicity, training background, and level of experience, so that these findings may be generalized to other populations of therapists.

Future Research Surrounding Affective, Behavioral, and Cognitive Countertransferential Reactions

In this study, therapists' affective manifestations of countertransference were assessed via self-report measures immediately following presentation of the vignettes. While this is a commonly used measurement approach adopted from other studies of countertransferential behavior (c.f. Hayes & Gelso, 1993; Sharkin & Gelso, 1993), affective manifestations of countertransference may also be assessed via therapists' physiological or autonomic reactions to clients' issues. Instead of therapists completing self-report measures of anxiety and mood following presentation of vignettes, therapists' countertransferential reactions might also be assessed via measurements of therapists' heart rate or skin conductance. These physiological measures may offer a more primitive measure of therapists' countertransferential reactions and address problems of administering self-report measures to therapists, such as therapists' providing socially acceptable responses or having more than laymen's knowledge about the purposes of self-report measures.

Future research may also adjust procedures used in this study to assess therapists' verbal responses to clients with schema-congruent issues. One limitation of the current procedure was the artificial manner in which therapists were asked to provide verbal responses to clients. Future research may use measurement techniques that more closely mirror the therapist/client interaction and are experienced as less contrived by participants. For example, future studies might provide unlimited verbal response time for therapists and allow therapists to determine the point in which they wish to respond to clients, as opposed to creating

predetermined stopping points and limiting the length of therapists' responses. To accomplish these aims, future research might involve retrospective investigations in which researchers analyze previous therapy sessions, an approach used in early investigations of countertransference.

Another approach, which may ameliorate the contrived nature of the audiotape procedure, would be to have therapists respond to videotaped case vignettes. Other investigations of countertransference (c.f. Hayes & Gelso, 1993; Sharkin & Gelso, 1993) have used videotaped case vignettes to measure therapists' countertransferential reactions. While this instrumentation may be more authentic and less contrived, videotaped vignettes might introduce new confounds such as clients' physical appearance, ethnic back ground, and nonverbal cues.

In terms of cognitive manifestations of countertransference, future research could explore therapists' accuracy for recall of client material as opposed to content. It might also be interesting to focus on therapists' ability to recall dependency-oriented words or phrases as function of therapists' own dependency-oriented self-schemas.

Another area of interest involves therapists' level of distress at the time of the experiment. As mentioned previously, it is unclear whether therapists' level of distress assessed in this study is in reaction to material presented in the vignettes, the nature of the procedure, or in reaction to factors unrelated to this study. Therapists' countertransferential feelings appear to play some role in predicting countertransferential behaviors therefore therapists' affective arousal during these kinds of investigations is of importance. Thus future research may explore more closely how level of distress mediates relationships between therapists-self-

schemata and countertransferential reactions toward clients with schema-congruent presenting issues.

Another interesting direction would be to explore schema activation and countertransference reactions to schema-congruent presenting issues in the context of psychotherapy groups. It seems that the multitude of issues and themes present in a therapy group would provide a rich context from which to explore therapists' countertransferential reactions to schema-congruent content and process.

Appendices

Appendix A

Young's (1999) Early Maladaptive Schemata with Descriptions and Domains (p.12-16)

Note: This is a revised list of EMS and some of these EMS are not represented in Young's Schema Questionnaire (1990).

I. Disconnection and Rejection - Expectation that one's needs for security, safety, stability, nurturance, empathy, sharing of feelings, acceptance, and respect will not be met in a predictable manner. Typical family of origin is detached, cold, rejecting, withholding, lonely, explosive, unpredictable, or abusive.

Abandonment/Instability. The perceived instability or unreliability of those available for support and connection. Involves the sense that significant others will not be able to continue providing emotional support, connection, strength, or practical protection because they are emotionally unstable and unpredictable (e.g., angry outbursts), unreliable, or erratically present; because they will die imminently; or because they will abandon the patient in favor of someone better.

Mistrust/Abuse. The expectation that others will hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage. Usually involves the perception that the harm is intentional or the result of unjustified and extreme negligence. May include the sense that one always ends up being cheated relative to others or "gets the short end of the stick."

Emotional Deprivation. Expectation that one's desire for a normal degree of emotional support will not b adequately met by others. The three major forms of deprivation are:

a. Deprivation of Nurturance - Absence of attention, affection, warmth, or companionship.
b. Deprivation of Empathy - Absence of understanding, listening, self-disclosure, or mutual sharing of feelings from others.
c. Deprivation of Protection - Absence of strength, direction, or guidance from others.

Defectiveness/Shame. The feeling that one is defective, bad, unwanted, inferior, or invalid in important respects; or that one would be unlovable to significant others if exposed. May involve hypersensitivity to criticism, rejection,

and blame; self-consciousness, comparisons, and insecurity around others; or a sense of shame regarding one's perceived flaws. These flaws may be private (e.g., selfishness, angry impulses, unacceptable sexual desires) or public (e.g., undesirable physical appearance, social awkwardness).

Social Isolation/Alienation. The feeling that one is isolated from the rest of the world, different from other people, and/or not part of any group or community.

II. Impaired Autonomy and Performance - Expectations about oneself and the environment that interfere with one's perceived ability to separate, survive, function independently, or perform successfully. Typical family of origin is enmeshed, undermining of child's confidence, overprotective, or failing to reinforce child for performing competently outside the family.

Dependence/Incompetence. Belief that one is unable to handle one'severyday responsibilities in a competent manner, without considerable help from others (e.g., take care of oneself, solve daily problems, exercise good judgement, tackle new tasks, make good decisions). Often presents as helplessness.

Vulnerability to Harm or Illness. Exaggerated fear that imminent catastrophe will strike at any time and that one will be unable to prevent it. Fears focus on one or more of the following: (a) Medical catastrophes - for example, heart attacks, AIDS; (b) Emotional Catastrophes - for example, going crazy; (c) External Catastrophes - for example, elevators collapsing, victimized by criminals, airplane crashes, earthquakes.

Enmeshment/Undeveloped Self. Excessive emotional involvement and closeness with one or more significant others (often parents), at the expense of full individuation or normal social development. Often involves the belief that at least one of the enmeshed individuals cannot survive or be happy without the constant support of the other. May also include feelings of being smothered by, or fused with, others or insufficient individual identity. Often experienced as a feeling of emptiness and floundering, having no direction, or, in extreme cases questioning one's existence.

Failure. The belief that one has failed, will inevitably fail, or is fundamentally inadequate relative to one's peers, in areas of achievement (school, career, sports, etc.). Often involves beliefs that one is stupid, inept, untalented, ignorant, lower in status, less successful than others, and so on.

III. Impaired Limits - Deficiency in internal limits, responsibility to others, or long-term goal-orientation. Leads to difficulty respecting the rights of others, cooperating with others, making commitments, or setting and meeting realistic personal goals. Typical family of origin is characterized by permissiveness, overindulgence, lack of direction, or a sense of superiority-rather than appropriate confrontation, discipline, and limits in relation to taking responsibility, cooperating in a reciprocal manner, and setting goals. In some cases, the child may not have been pushed to tolerate normal levels of discomfort or may not have been given adequate supervision, direction, or guidance.

Entitlement/Grandiosity. The belief that one is superior to other people; entitled to special rights and privileges; or not bound by the rules of reciprocity that guide normal social interaction. Often involves insistence that one should be able to do or have whatever one wants, regardless of what is realistic, what others consider reasonable, or the cost to others; or an exaggerated focus on superiority (e.g., being among the most successful, famous, wealthy)-in order to achieve power or control (not primarily for attention or approval). Sometimes includes excessive competitiveness toward, or domination of, others: asserting one's power, forcing one's point of view, or controlling the behavior of others in line with one's own desires-without empathy or concern for others' needs or feelings.

Insufficient Self-Control/Self-Discipline. Pervasive difficulty or refusal to exercise sufficient self-control and frustration tolerance to achieve one's personal goals, or to restrain the excessive expression of one's emotions and impulses. In its milder form, patient presents with an exaggerated emphasis on discomfort-avoidance: avoiding pain, conflict, confrontation, responsibility, or overexertion-at the expense of personal fulfillment, commitment, or integrity.

IV. Other-Directedness - An excessive focus on the desires, feelings, and responses of others, at the expense of one's own needs-in order to gain love and approval, maintain one's sense of connection, or avoid retaliation. Usually involves suppression and lack of awareness regarding one's own anger and natural inclinations. Typical family of origin is based on conditional acceptance: children must suppress important aspects of themselves in order to gain love, attention, and approval. In many such families, the parents' emotional needs and desires-or social acceptance and status-are valued more than the unique needs and feelings of each child.

Subjugation. Excessive surrendering of control to others because one feels coerced-usually to avoid anger, retaliation, or abandonment. The two major forms of subjugation are:

a. Subjugation of Needs - Suppression of one's preferences, decisions, and desires.
b. Subjugation of Emotions - Suppression of emotional expression, especially anger.

Usually involves the perception that one's own desires, opinions, and feelings are not valid or important to others. Frequently presents as excessive compliance, combined with hypersensitivity to feeling trapped. Generally leads to a build up of anger, manifested in maladaptive symptoms (e.g., passive-aggressive behavior, uncontrolled outbursts of temper, psychosomatic symptoms, withdrawal of affection, "acting out," substance abuse.)

Self-Sacrifice. Excessive focus on voluntarily meeting the needs of others in daily situations, at the expense of one's own gratification. The most common reasons are to prevent causing pain to others, to avoid guilt from feeling selfish, or to maintain the connection with others perceived as needy. Often results from an acute sensitivity to the pain of others. Sometimes leads to a sense that one's own needs are not being adequately met and to resentment of those who are not taken care of. (Overlaps with concept of codependency).

Approval-Seeking/Recognition-Seeking. Excessive emphasis on gaining approval, recognition, or attention from other people, or fitting in, at the expense of developing a secure and true sense of self. One's sense of esteem is dependent primarily on the reaction of others rather than on one's own natural inclinations. Sometimes includes an overemphasis on status, appearance, social acceptance, money, or achievement- as a means of gaining approval, admiration, or attention (not primarily for power or control). Frequently results in major life decisions that are inauthentic or unsatisfying; or hypersensitivity to rejection.

V. Overvigilance and Inhibition - Excessive emphasis on suppressing one's spontaneous feelings, impulses, and choices or on meeting rigid, internalized rules and expectations about performance and ethical behavior-often at the expense of happiness, self-expression, relaxation, close relationships, or health. Typical

family origin is grim, demanding, and sometimes punitive: performance, duty, perfectionism, following rules, hiding emotions, and avoiding mistakes predominate over pleasure, joy, and relaxation. There is usually an undercurrent of pessimism and worry-that things could fall apart if one fails to be vigilant and careful at all times.

Negativity/Pessimism. A pervasive, lifelong focus on the negative aspects of life (pain, death, loss, disappointment, conflict, guilt, resentment, unresolved problems, potential mistakes, betrayal, things that could go wrong, etc.) while

minimizing or neglecting the positive or optimistic aspects. Usually includes an exaggerated expectation-in a wide range of work, financial, or interpersonal situations-that things will eventually go seriously wrong, or that aspects of one's life that seem to be going well will ultimately fall apart. Usually involves an inordinate fear of making mistakes that might lead to financial collapse, loss, humiliation, or being trapped in a bad situation. Because potential negative outcomes are exaggerated, these patients are frequently characterized by chronic worry, complaining, or indecision.

Emotional Inhibition. The excessive inhibition of spontaneous action, feeling, or communication-usually to avoid disapproval by others, feelings of shame, or losing control of one's impulses. The most common areas of inhibition involve: (a) inhibition of anger and aggression; (b) inhibition of positive impulses (e.g., joy, affection, sexual excitement, play); (c) difficulty expressing vulnerability or communicating freely about one's feelings, needs, and so on; or (d) excessive emphasis on rationality while disregarding emotions.

Unrelenting Standards/Hypercriticalness. The underlying belief that one must strive to meet very high internalized standards of behavior and performance usually to avoid criticism. Typically results in feelings of pressure or difficulty slowing down, and in hypercriticalness toward oneself and others. Must involve significant impairment in pleasure, relaxation, health, self-esteem, sense of accomplishment, or satisfying relationships. Unrelenting standards typically present as (a) perfectionism, inordinate attention to detail, or an underestimate of how good one's own performance is relative to the norm; (b) rigid rules and "shoulds" in many areas of life, including unrealistically high moral, ethical, cultural, or religious precepts; or (c) preoccupation with time and efficiency so that more can be accomplished.

Punitiveness. The belief that people should be harshly punished for making mistakes. Involves the tendency to be angry, intolerant, punitive, and inpatient with those people (including oneself) who do not meet one' s expectations or standards. Usually includes difficulty forgiving mistakes in oneself or others because of a reluctance to consider extenuating circumstances, allow for human imperfection, or empathize with feelings.

Appendix B

Demographic Characteristics of Sample

	Percent	Frequency
Sex		
Males	20	10
Females	80	40
Ethnicity		
African American	6	3
Asian American/Pacific Islander	6	3
Latino/Hispanic	8	4
European Origin/White	80	40
Age		
21-30 yrs.	66	33
31-40 yrs.	22	11
41-50 yrs.	10	5
51-60 yrs.	2	1
Current Degree		
B.A./B.S.	24	12
M.A./M.. S.	54	27
M.Ed.	10	5
M.S.W.	6	3
Ph.D.	6	3
Area of Current Degree		
Psychology	20	10
Clinical Psychology	16	8
Counseling Psychology	28	14
Social Work	6	3
School Psychology	10	5
Counselor Education	6	3
Clinical/Counseling Psychology	2	1
Other	12	6

Currently Pursuing a Degree		
Yes	90	45
No	10	5
Area of Current Degree Program		
Clinical Psychology	14	7
Counseling Psychology	62	31
School Psychology	12	6
Clinical/Counseling Psychology	2	1
Licenses and Credentials		
L.P.C	2	1
LMSW	2	1
LSSP	2	1
Licensed Psychologist	2	1
Other	4	2
Years of Therapy Experience		
1-3 yrs.	58	29
4-7 yrs.	38	19
8-11 yrs.	4	2
Previous Personal Therapy		
Yes	82	41
No	18	9
Years of Previous Personal Therapy		
0-3 yrs	58	29
4-7 yrs.	10	5
8-11 yrs.	12	6
12-15 yrs.	2	1
Not any	18	9

Appendix C

VIGNETTE #1- BARBARA

Instructions: Please read the following paragraph about the client you are about to hear on this audiotape. At two different points during this vignette, you will be instructed to provide a response you would say to the client at that particular point in the session. You will hear a bell that will indicate when you are supposed to begin speaking your response out loud, and another bell will indicate when you should begin to end or wrap-up your response. You will be speaking your responses into a separate tape recorder and you will have approximately 30 seconds for each response. These responses can be brief, two or three sentence responses to this client. They can be either statements or questions, and should reflect your most immediate reactions to this client. Your responses will not be played back or critiqued. We are merely interested in the kinds of responses these vignettes elicit from therapists.

After you have given your second verbal response, you will be asked to complete the questions on the following page. Now please read the following paragraph about the client you are about to listen to and wait for the vignette to begin.

Barbara is a 19 year-old Caucasian female whom you have seen for two previous sessions. She is an undergraduate biology major at The University of Texas at Austin. Since beginning college, Barbara has felt relatively certain that she wanted to be a doctor. However, after taking some biology and chemistry classes and living with friends with different majors, Barbara is not sure she wants to devote the rest of her life to medicine. In addition, Barbara's parents have recently been giving her a hard time about getting serious about her education and choosing a career. Furthermore, Barbara's parents constantly compare her to her over-achieving older sister, who has just accepted a job in a prestigious law firm.

STOP! DO NOT TURN THE PAGE UNTIL YOU ARE INSTRUCTED TO DO SO!

Please answer the following four questions with respect to Barbara using this 6-point scale:

1 - Strongly Disagree
2 - Disagree
3 - Slightly Disagree
4 - Slightly Agree
5 - Agree
6 - Strongly agree

____ 1. I feel warmth toward the client I just heard in the audiotape.
____ 2. I like the client I just heard in the audiotape.
____ 3. I believe the client I just heard in the audiotape will improve a lot in therapy.
____ 4. I feel empathy toward the client I just heard in the audiotape.

Read each statement and then circle the most appropriate number to the right of the statement to indicate how you feel at this moment in the **presence of this client**. There are no right or wrong answers. Do not spend too much time on any one statement, but give the answer which seems to describe **your present feelings best.**

	Not at all	Somewhat	Moderately	Very Much
1. I feel calm	1	2	3	4
2. I am tense	1	2	3	4
3. I feel upset	1	2	3	4
4. I am relaxed	1	2	3	4
5. I feel content	1	2	3	4
6. I am worried	1	2	3	4

STOP! DO NOT TURN THE PAGE
UNTIL YOU ARE INSTRUCTED TO DO SO!

VIGNETTE #2- JUDY

Instructions: On the next four vignettes, you will follow this same procedure. First, you will read a paragraph about the client you are about to hear on the audiotape. While you are listening to the vignette, you will hear a bell that will indicate when you are supposed to begin speaking your response out loud, and another bell will indicate when you should begin to end or wrap-up your response. Remember, it is important that both of your responses reflect your most immediate reactions to the client. Finally, you will complete the questions on the following page about the vignette you just heard. Please read the following paragraph about the client you are about to listen to and wait for the vignette to begin.

Judy is a 23 year-old Caucasian female whom you have seen for five previous sessions. She is an undergraduate at The University of Texas at Austin studying music. Her parents are married and live in Dallas. Judy transferred to UT to be with her ex-boyfriend, Zachary, and has been in several consecutive romantic relationships for the past 5 or so years. The majority of her therapy sessions have explored her current relationship with her boyfriend, Brad. She is distraught in this week's session as Brad has abruptly ended the relationship.

STOP! DO NOT TURN THE PAGE
UNTIL YOU ARE INSTRUCTED TO DO SO!

Please answer the following four questions with respect to Judy using this 6-point scale:

1 - Strongly Disagree
2 - Disagree
3 - Slightly Disagree
4 - Slightly Agree
5 - Agree
6 - Strongly agree

____ 1. I feel warmth toward the client I just heard in the audiotape.
____ 2. I like the client I just heard in the audiotape.
____ 3. I believe the client I just heard in the audiotape will improve a lot in therapy.
____ 4. I feel empathy toward the client I just heard in the audiotape.

Read each statement and then circle the most appropriate number to the right of the statement to indicate how you feel at this moment in the **presence of this client**. There are no right or wrong answers. Do not spend too much time on any one statement, but give the answer which seems to describe **your present feelings best.**

	Not at all	Somewhat	Moderately	Very Much
1. I feel calm	1	2	3	4
2. I am tense	1	2	3	4
3. I feel upset	1	2	3	4
4. I am relaxed	1	2	3	4
5. I feel content	1	2	3	4
6. I am worried	1	2	3	4

STOP! DO NOT TURN THIS PAGE
UNTIL YOU ARE INSTRUCTED TO DO SO!

VIGNETTE #3- MARGARET

Please read the following paragraph about the client you are about to listen to and wait for the vignette to begin.

Margaret is a 24 year-old Caucasian female whom you have seen for five previous sessions. She is a doctoral student at The University of Texas at Austin studying theater and dance. Margaret 's previous sessions have focused on school-related stress. She is distraught in this week's session as she was not selected for fellowship in her academic department despite having researched it on the Internet.

STOP! DO NOT TURN THIS PAGE
UNTIL YOU ARE INSTRUCTED TO DO SO!

Please answer the following four questions with respect to Margaret using this 6-point scale:

1 - Strongly Disagree
2 - Disagree
3 - Slightly Disagree
4 - Slightly Agree
5 - Agree
6 - Strongly agree

____ 1. I feel warmth toward the client I just heard in the audiotape.
____ 2. I like the client I just heard in the audiotape.
____ 3. I believe the client I just heard in the audiotape will improve a lot in therapy.
____ 4. I feel empathy toward the client I just heard in the audiotape.

Read each statement and then circle the most appropriate number to the right of the statement to indicate how you feel at this moment in the **presence of this client**. There are no right or wrong answers. Do not spend too much time on any one statement, but give the answer which seems to describe **your present feelings best.**

	Not at all	Somewhat	Moderately	Very Much
1. I feel calm	1	2	3	4
2. I am tense	1	2	3	4
3. I feel upset	1	2	3	4
4. I am relaxed	1	2	3	4
5. I feel content	1	2	3	4
6. I am worried	1	2	3	4

STOP! DO NOT TURN THIS PAGE
UNTIL YOU ARE INSTRUCTED TO DO SO!

VIGNETTE #4- MARY ANN

Please read the following paragraph about the client you are about to listen to and wait for the vignette to begin.

Mary Ann is a 20 year-old Caucasian female whom you have seen for five previous sessions. She is an undergraduate at The University of Texas at Austin. Her parents and younger sister live in Austin. Mary Ann's primary complaints are depressed mood and anxiety. She is distraught in this week's session as she is feeling alienated by her best friend and roommate, Carrie, and her parents have decided to move out of state.

STOP! DO NOT TURN THIS PAGE
UNTIL YOU ARE INSTRUCTED TO DO SO!

Please answer the following four questions with respect to Mary Ann using this 6-point scale:

1 - Strongly Disagree
2 - Disagree
3 - Slightly Disagree
4 - Slightly Agree
5 - Agree
6 - Strongly agree

____ 1. I feel warmth toward the client I just heard in the audiotape.
____ 2. I like the client I just heard in the audiotape.
____ 3. I believe the client I just heard in the audiotape will improve a lot in therapy.
____ 4. I feel empathy toward the client I just heard in the audiotape.

Read each statement and then circle the most appropriate number to the right of the statement to indicate how you feel at this moment in the **presence of this client**. There are no right or wrong answers. Do not spend too much time on any one statement, but give the answer which seems to describe **your present feelings best.**

	Not at all	Somewhat	Moderately	Very Much
1. I feel calm	1	2	3	4
2. I am tense	1	2	3	4
3. I feel upset	1	2	3	4
4. I am relaxed	1	2	3	4
5. I feel content	1	2	3	4
6. I am worried	1	2	3	4

STOP! DO NOT TURN THIS PAGE
UNTIL YOU ARE INSTRUCTED TO DO SO!

VIGNETTE #5- TERRY

Please read the following paragraph about the client you are about to listen to and wait for the vignette to begin.

Terry is a 19 year-old Caucasian female whom you have seen for two previous sessions. Her parents are divorced and live out of town. She works in the radio/television industry. Terry's previous sessions focused on job-related stress and loneliness. She is distraught in this week's session as she was not selected for a promotion at her radio station.

STOP! DO NOT TURN THIS PAGE
UNTIL YOU ARE INSTRUCTED TO DO SO!

Please answer the following four questions with respect to Terry using this 6-point scale:

1 - Strongly Disagree
2 - Disagree
3 - Slightly Disagree
4 - Slightly Agree
5 - Agree
6 - Strongly agree

____ 1. I feel warmth toward the client I just heard in the audiotape.
____ 2. I like the client I just heard in the audiotape.
____ 3. I believe the client I just heard in the audiotape will improve a lot in therapy.
____ 4. I feel empathy toward the client I just heard in the audiotape.

Read each statement and then circle the most appropriate number to the right of the statement to indicate how you feel at this moment in the **presence of this client**. There are no right or wrong answers. Do not spend too much time on any one statement, but give the answer which seems to describe **your present feelings best.**

	Not at all	Somewhat	Moderately	Very Much
1. I feel calm	1	2	3	4
2. I am tense	1	2	3	4
3. I feel upset	1	2	3	4
4. I am relaxed	1	2	3	4
5. I feel content	1	2	3	4
6. I am worried	1	2	3	4

STOP! DO NOT TURN THIS PAGE UNTIL YOU ARE INSTRUCTED TO DO SO!

Appendix D

Brief Symptom Inventory

Below is a list of problems people sometimes have. Please read each one carefully, and select the statement that best describes HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY. Only select one statement for each item and do not skip any items. If you change your mind, erase your first mark carefully.

Rating scale:

1-Not at all
2-A little bit
3-Moderately
4-Quite a Bit
5- Extremely

HOW MUCH WERE YOU DISTRESSED BY:

___ Nervousness or shakiness inside
___ Faintness or dizziness
___ The idea that someone else can control your thoughts
___ Feeling others are to blame for most of your troubles
___ Trouble remembering things

___ Feeling easily annoyed or irritated
___ Pains in heart or chest
___ Feeling afraid in open spaces or on the streets
___ Thoughts of ending your life
___ Feeling that most people cannot be trusted

___ Poor appetite
___ Suddenly scared for no reason
___ Temper outbursts that you could not control
___ Feeling lonely even when you are with people
___ Feeling blocked in getting things done

___ Feeling lonely
___ Feeling blue
___ Feeling no interest in things

___ Feeling fearful
___ Your feelings being easily hurt
___ Feeling that people are unfriendly or dislike you
___ Feeling inferior to others
___ Nausea or upset stomach
___ Feeling that you are watched or talked about by others
___ Trouble falling asleep
___ Having to check and double-check what you do
___ Difficulty making decisions
___ Feeling afraid to travel on buses, subways, or trains

___ Trouble getting your breath
___ Hot or cold spells
___ Having to avoid certain things, places, or activities, because they frighten you
___ Your mind going blank
___ Numbness or tingling in parts of your body

___ The idea that you should be punished for your sins
___ Feeling hopeless about the future
___ Trouble concentrating
___ Feeling weak in parts of your body
___ Feeling tense or keyed up

___ Thoughts of death or dying
___ Having urges to beat, injure, or harm someone
___ Having urges to break or smash things
___ Feeling very self-conscious with others
___ Feeling uneasy in crowds, such as shopping or at a movie
___ Never feeling close to another person
___ Spells of terror or panic
___ Getting into frequent arguments
___ Feeling nervous when you are left alone

___ Others not giving you proper credit for your achievements
___ Feeling so restless you couldn't sit still
___ Feelings of worthlessness
___ Feeling that people will take advantage of you if you let them
___ Feelings of guilt
___ The idea that something is wrong with your mind

Appendix E

Young's (1990) Schema Questionnaire - (Second Edition)

Note: The YSQ-L assesses EMS developed by Young in 1990, and does not reflect revisions of EMS made in 1999.

Instructions: Listed below are statements that a person might use to describe himself or herself. Please read each statement and decide how well it describes you. When you are not sure, base your answer on what you emotionally feel, and not on what you think to be true.

If you desire, reword the statement so that the statement would be even more true of you. Then choose the highest rating from 1 to 6 that describes you (including your revisions), and write the number in the space before the statement.

Rating scale:

1 = Completely untrue of me
2 = Mostly untrue of me
3 = Slightly untrue of me
4 = Moderately untrue of me
5 = Mostly untrue of me
6 = Describes me perfectly

Example:

_4_ I worry that people will not like me.
1. __ People have not been there to meet my emotional needs.
2. __ I haven't gotten love and attention.
3. __ For the most part, I haven't had someone to depend on for advice and emotional support.
4. __ Most of the time, I haven't had someone to nurture me, share himself/herself with me, or care deeply about everything that happens to me.
5. __ For much of my life, I haven't had someone who wanted to get close to me and spend a lot of time with me.
6. __ In general, people have not been there to give me warmth, holding, and affection.
7. __ For much of my life, I haven't felt that I am special to someone.

8. __ For the most part, I have not had someone who really listens to me, understands me, or is tuned into my true needs and feelings.
9. __ I have rarely had a strong person to give me sound advice or direction when I'm not sure what to do.
10. __ I worry that people I love will die soon, even though there is little medical reason to support my concern.
11. __ I find myself clinging to people I am close to because I'm afraid they'll leave me.
12. __ I worry that people I feel close to will leave me or abandon me.
13. __ I feel that I lack a stable base of emotional support.
14. __ I don't feel that important relationships will last; I expect them to end.
15. __ I feel addicted to partners who can't be there for me in a committed way.
16. __ In the end, I will be alone.
17. __When I feel someone I care for pulling away from me, I get desperate.
18. __ Sometimes I am so worried about people leaving me that I drive them away.
19. __ I become upset when someone leaves me alone, even for a short period of time.
20. __ I can't count on people who support me to be there on a regular basis.
21. __ I can't let myself get really close to other people because I can't be sure they'll always be there.
22. __ It seems that the important people in my life are always coming and going.
23. __ I worry a lot that the people I love will find someone else they prefer and leave me.
24. __ The people close to me have been very unpredictable; one moment they're available and nice to me; the next, they're angry, upset, self-absorbed, fighting, and so on.
25. __ I need other people so much that I worry about losing them.
26. __ I feel so defenseless if I don't have people to protect me that I worry a lot about losing them.
27. __ I can't be myself or express what I really feel, or people will leave me.
28. __ I feel that people will take advantage of me.
29. __ I often feel that I have to protect myself from other people.
30. __ I feel that I cannot let my guard down in the presence of other people, or else they will intentionally hurt me.
31. __ If someone acts nicely towards me, I assume that he/she must be after something.
32. __ It is only a matter of time before someone betrays me.
33. __ Most people only think about themselves.
34. __ I have a great deal of difficulty trusting people.

35. __ I am quite suspicious of other people's motives.
36. __ Other people are rarely honest; they are usually not what they appear.
37. __ I'm usually on the lookout for people's ulterior motives.
38. __ If I think someone is out to hurt me, I try to hurt them first.
39. __ People usually have to prove themselves to me before I can trust them.
40. __ I set up "tests" for other people to see if they are telling me the truth and are well-intentioned.
41. __ I subscribe to the belief: "Control or be controlled."
42. __ I get angry when I think about the ways I have been mistreated by other people throughout my life.
43. __ Throughout my life, those close to me have taken advantage of me or used me for their own purposes.
44. __ I have been physically, emotionally, or sexually abused by important people in my life.
45. __ I don't fit in.
46. __ I'm fundamentally different from other people.
47. __ I don't belong; I'm a loner.
48. __ I feel alienated from other people.
49. __ I feel isolated and alone.
50. __ I always feel on the outside of groups.
51. __ No one really understands me.
52. __ My family was always different from the families around us.
53. __ I sometimes feel as if I'm an alien.
54. __ If I disappeared tomorrow, no one would notice.
55. __ No man/woman I desire could love me once he/she saw my defects.
56. __ No one I desire would want to stay close to me if he/she knew the real me.
57. __ I am inherently flawed and defective.
58. __ No matter how hard I try, I feel that I won't be able to get a significant man/woman to respect me or feel that I am worthwhile.
59. __ I'm unworthy of the love, attention, and respect of others.
60. __ I feel that I'm not lovable.
61. __I am too unacceptable in very basic ways to reveal myself to other people.
62. __ If others found out about my basic defects, I could not face them.
63. __ When people like me, I feel I am fooling them.
64. __ I often find myself drawn to people who are very critical or reject me.
65. __ I have inner secrets that I don't want people close to me to find out.
66. __ It is my fault that my parent(s) could not love me enough.
67. __ I don't let people know the real me.
68. __ One of my greatest fears is that my defects will be exposed.
69. __ I cannot understand how anyone could love me.

70. __ I'm not sexually active.
71. __ I'm too fat.
72. __ I'm ugly.
73. __ I can't carry on a decent conversation.
74. __ I'm dull and boring in social situations.
75. __ People I value wouldn't associate with me because of my social status (e.g., income, educational level, career).
76. __ I never know what to say socially.
77. __ People don't want to include me in their groups.
78. __ I am very self-conscious around other people.
79. __ Almost nothing I do at work (or school) is as good as what other people can do.
80. __ I'm incompetent when it comes to achievement.
81. __ Most other people are more capable than I am in areas of work and achievement.
82. __ I'm a failure.
83. __ I'm not as talented as most people are at their work.
84. __ I'm not as intelligent as most people when it comes to work (or school).
85. __ I am humiliated by my failures and inadequacies in the work sphere.
86. __ I often feel embarrassed around other people because I don't measure up to them in terms of my accomplishments.
87. __ I often compare my accomplishments with others and feel that they are much more successful.
88. __ I do not feel capable of getting by on my own in everyday life.
89. __ I need other people to help me get by.
90. __ I do not feel I can cope well by myself.
91. __ I believe that other people can take care of me better than I can take care of myself.
92. __ I have trouble tackling new tasks outside of work unless I have someone to guide me.
93. __ I think of myself as a dependent person, when it comes to everyday functioning.
94. __ I screw up everything I try, even outside of work (or school).
95. __ I'm inept in most areas of my life.
96. __ If I trust my own judgement in everyday situations, I'll make the wrong decision.
97. __ I lack common sense.
98. __ My judgement cannot be relied upon in everyday situations.
99. __ I don't feel confident about my ability to solve everyday problems that come up.
100. __ I feel I need someone I can rely on to give me advice about practical issues.

101. __ I feel more like a child than an adult when it comes to handling everyday responsibilities.
102. __ I find the responsibilities of everyday life overwhelming.
103. __ I can't seem to escape the feeling that something bad is about to happen.
104. __I feel that a disaster (natural, criminal, financial, or medical) could strike at any moment.
105. __ I worry about becoming a street person or vagrant.
106. __ I worry about being attacked.
107. __ I feel that I must be very careful about money or else I might end up with nothing.
108. __ I take great precautions to avoid getting sick or hurt.
109. __ I worry that I'll lose all my money and become destitute.
110. __ I worry that I'm developing a serious illness, even though nothing serious has been diagnosed by a physician.
111. __ I am a fearful person.
112. __ I worry a lot about the bad things happening in the world: crime, pollution, and so on.
113. __ I often feel that I might go crazy.
114. __ I often feel that I'm going to have an anxiety attack.
115. __ I often worry that I might have a heart attack, even though there is little medical reason to be concerned.
116. __ I feel that the world is a dangerous place.
117. __ I have not been able to separate myself from my parent(s), the way other people my age seem to.
118. __ My parent(s) and I tend to be overinvolved in each other's lives and problems.
119. __ It is very difficult for my parent(s) and me to keep intimate details from each other, without feeling betrayed or guilty.
120. __ My parent(s) and I have to speak to each other almost every day or else one of us feels guilty, hurt, disappointed, or alone.
121. __ I often feel that I do not have a separate identity from my parents or partner.
122. __ I often feel as if my parents are living through me – I don't have a life of my own.
123. __ It is very difficult for me to maintain any distance from the people I am intimate with; I have trouble keeping any separate sense of myself.
124. __ I am so involved with my partner or parents that I do not really know who I am or what I want.
125. __ I have trouble separating my point of view or opinion from that of my parents or partner.
126. __ I often feel that I have no privacy when it comes to my parents or partner.

127. __ I feel that my parents are, or would be, very hurt about my living on my own, away from them.
128. __ I let other people have their way because I fear the consequences.
129. __ I think if I do what I want, I'm only asking for trouble.
130. __ I feel that I have no choice but to give in to other peoples' wishes, or else they will retaliate or reject me in some way.
131. __ In relationships, I let the other person have the upper hand.
132. __ I've always let others make choices for me, so I really don't know what I want for myself.
133. __ I feel the major decisions in my life were not really my own.
134. __ I worry a lot about pleasing other people so they won't reject me.
135. __ I have a lot of trouble demanding that my rights be respected and that my feelings be taken into account.
136. __ I get back at people in little ways instead of showing my anger.
137. __ I will go to much greater lengths than most people to avoid confrontations.
138. __I put others' needs before my own or else I feel guilty.
139. __ I feel guilty when I let other people down or disappoint them.
140. __ I give more to other people than I get back in return.
141. __I'm the one who usually ends up taking care of the people I'm close to.
142. __ There is almost nothing I couldn't put up with if I loved someone.
143. __ I am a good person because I think of others more than of myself.
144. __ At work, I'm usually the one to volunteer to do extra tasks or to put in extra time.
145. __ No matter how busy I am, I can always find time for others.
146. __ I can get by on very little because my needs are minimal.
147. __ I'm only happy when those around me are happy.
148. __ I'm so busy doing for the people that I care about that I have little time for myself.
149. __ I've always been the one who listens to everyone else's problems.
150. __ I'm more comfortable giving a present than receiving one.
151. __ Other people see me as doing too much for others and not enough for myself.
152. __ No matter how much I give, it is never enough.
153. __ If I do what I want, I feel very uncomfortable.
154. __ It's very difficult for me to ask others to take care of my needs.
155. __ I worry about losing control of my actions.
156. __ I worry that I might seriously harm someone physically or emotionally if my anger gets out of control.
157. __ I feel that I must control my emotions and impulses or something bad is likely to happen.

158. __ A lot of anger and resentment build up inside of me that I don't express.
159. __ I am too self-conscious to show positive feelings to others (e.g., affection, showing I care).
160. __ I find it embarrassing to express my feelings to others.
161. __ I find it hard to be warm and spontaneous.
162. __ I control myself so much that people think I am unemotional.
163. __ People see me as uptight emotionally.
164. __ I must be the best at most of what I do; I can't accept second best.
165. __ I strive to keep almost everything in perfect order.
166. __ I must look my best most of the time.
167. __ I try to do my best; I can't settle for "good enough."
168. __ I have so much to accomplish that there is almost no time to really relax.
169. __ Almost nothing I do is quite good enough; I can always do better.
170. __ I must meet all my responsibilities.
171. __ I feel there is constant pressure for me to achieve and get things done.
172. __ My relationships suffer because I push myself so hard.
173. __ My health is suffering because I put myself under so much pressure to do well.
174. __ I often sacrifice pleasure and happiness to meet my own standards.
175. __ When I make a mistake, I deserve strong criticism.
176. __I can't let myself off the hook easily or make excuses for my mistakes.
177. __ I'm a very competitive person.
178. __ I put a good deal of emphasis on money or status.
179. __ I always have to be "Number One," in terms of my performance.
180. __ I have a lot of trouble accepting "no" for an answer when I want something from other people.
181. __ I often get angry or irritable if I can't get what I want.
182. __ I'm special and shouldn't have to accept many of the restrictions placed on other people.
183. __ I hate to be constrained or kept from doing what I want.
184. __ I feel that I shouldn't have to follow the normal rules and conventions other people do.
185. __ I feel that what I have to offer is of greater value than the contributions of others.
186. __ I usually put my needs ahead of the needs of others.
187. __ I often find that I am so involved in my own priorities that I don't have time to give to friends or family.
188. __ People often tell me I am very controlling about the ways things are done.

189. __ I get very irritated when people won't do what I ask of them.
190. __ I can't tolerate other people telling me what to do.
191. __ I have great difficulty getting myself to stop drinking, smoking, overeating, or other problem behaviors.
192. __ I can't seem to discipline myself to complete routine or boring tasks.
193. __ Often I allow myself to carry through on impulses and express emotions that get me into trouble or hurt other people.
194. __ If I can't reach a goal, I become easily frustrated and give up.
195. __ I have a very difficult time sacrificing immediate gratification to achieve a long-range goal.
196. __ It happens that, once I start to feel angry, I just can't control it.
197. __ I tend to overdo things, even though I know they are bad for me.
198. __ I get bored very easily.
199. __When tasks become difficult, I usually cannot persevere and complete them.
200. __ I can't concentrate on anything for too long.
201. __ I can't force myself to do things I don't enjoy, even when I know it's for my own good.
202. __ I lose my temper at the slightest offense.
203. __ I have rarely been able to stick to my resolutions.
204. __ I can almost never hold back from showing people how I really feel, no matter what the cost may be
205. __ I often do things impulsively that I later regret.

Appendix F

Personal Style Inventory - II

Instructions: Here are a number of statements about personal characteristics. Please read each one carefully, and indicate whether you agree or disagree, and to what extent, by choosing an answer choice.

Rating scale:

1-Strongly disagree
2- Disagree
3- Slightly disagree
4- Slightly agree
5- Agree
6- Strongly agree

1. ___ I often put other people's needs before my own.
2. ___ I tend to keep other people at a distance.
3. ___ I find it difficult to be separated from people I love.
4. ___ I am easily bothered by other people making demands of me.
5. ___ I am very sensitive to the effects I have on the feelings of other people.
6. ___ I don't like relying on others for help.
7. ___ I am very sensitive to criticism by others.
8. ___ It bothers me when I feel that I am only average and ordinary.
9. ___ I worry a lot about hurting or offending other people.
10. ___ When I'm feeling blue, I don't like to be offered sympathy.
11. ___ It is hard for me to break off a relationship even if it is making me unhappy.
12. ___ In relationships, people are often too demanding of one another.
13. ___ I am easily persuaded by others.
14. ___ I usually view my performance as either a complete success or a complete failure.
15. ___ I try to please other people too much.
16. ___ I don’t like people to invade my privacy.
17. ___ I find it difficult if I have to be alone all day.
18. ___ It is hard for me to take instructions from people who have authority over me.
19. ___ I often feel responsible for solving other people's problems.

20. ___ I often handle big decisions without telling anyone else about them.
21. ___ It is very hard for me to get over the feeling of loss when a relationship has ended.
22. ___ It is hard for me to have someone dependent on me.
23. ___ It is very important to me to be liked or admired by others.
24. ___ I feel badly about myself when I am not actively accomplishing things.
25. ___ I feel I have to be nice to other people.
26. ___ It is hard for me to express admiration or affection.
27. ___ I like to be certain that there is somebody close I can contact in case something unpleasant happens to me.
28. ___ It is difficult for me to make a long-term commitment to a relationship.
29. ___ I am too apologetic to other people.
30. ___ It is hard for me to open up and talk about my feelings and other personal things.
31. ___ I am very concerned with how people react to me.
32. ___ I have a hard time forgiving myself when I feel I haven't worked up to my potential.
33. ___ I get very uncomfortable when I'm not sure whether or not someone likes me.
34. ___ When making a big decision, I usually feel that advice from others is intrusive.
35. ___ It is hard for me to say "no" to other people's requests.
36. ___ I resent it when people try to direct my behavior or activities.
37. ___ I become upset when something happens to me and there's nobody around to talk to.
38. ___ Personal questions from others usually feel like an invasion of my privacy.
39. ___ I am most comfortable when I know my behavior is what others expect of me.
40. ___ I am very upset when other people or circumstances interfere with my plans.
41. ___ I often let people take advantage of me.
42. ___ I rarely trust the advice of others when making a big decision.
43. ___ I become very upset when a friend breaks a date or forgets to call me as planned.
44. ___ I become upset more than most people I know when limits are placed on my personal independence and freedom.
45. ___ I judge myself based on how I think others feel about me.
46. ___ I become upset when others try to influence my thinking on a problem.

47. ___ It is hard for me to let people know when I am angry with them.
48. ___ I feel controlled when others have a say in my plans.

Appendix G

Demographic Information Sheet

Please create your own participant identification number, using no more than 4 numbers: _____

Please circle your responses to the following questions:

1. What is your ethnicity?
   - 1- African-American/Black/African Origin
   - 2- Asian-American/Asian Origin/Pacific Islander
   - 3- Latino-a/Hispanic
   - 4- American Indian/Alaska Native/Aboriginal Canadian
   - 5- European Origin/White
   - 6- Bi-racial/Multi-racial
   - 7- Other _____

2. What is your sex?
   - 1- Male
   - 2- Female

3. How old are you?
   - 1- 21 - 30 years old
   - 2- 31- 40 years old
   - 3- 41 - 50 years old
   - 4- 51 - 60 years old
   - 5- 61 - 70 years old
   - 6- 71 - 80 years old
   - 7- 81+ years old

4. What is the highest academic degree you CURRENTLY hold?

   - 1-Bachelor of Arts/Bachelor of Sciences (B.A./B.S.)
   - 2-Master of Arts/ Master of Science (M.A./M.S.)
   - 3-Master of Education (M.Ed.)
   - 4-Master of Social Work (M.S.W.)
   - 5-Doctor of Philosophy (Ph.D.)
   - 6-Doctor of Psychology (Psy.D.)

5. What was the major area of study in which you completed this degree?

1- Psychology
2-Clinical Psychology
3-Counseling Psychology
4- Social Work
5- School Psychology
6- Counselor Education
7- Clinical/Counseling Psychology
8- Other: _____

6. Are you CURRENTLY WORKING TOWARD a graduate degree?

1- Yes
2- No

If you answered "No" LEAVE QUESTIONS 7 AND 8 BLANK AND GO TO QUESTIONS 9 THROUGH 12.

If you answered "Yes" please continue to Question 7.

7. What is the degree you are CURRENTLY WORKING TOWARD**?**

1-Master of Arts/ Master of Science (M.A./M.S.)
2-Master of Education (M.Ed.)
3-Master of Social Work (M.S.W.)
4-Doctor of Philosophy (Ph.D.)
5-Doctor of Psychology (Psy.D.)

8. What is the major area of study of the degree you are CURRENTLY WORKING TOWARD?

1- Clinical Psychology
2- Counseling Psychology
3- Social Work
4- School Psychology
5- Counselor Education
6- Clinical/Counseling Psychology

7-Other: _____

9. Please circle ALL the licensures and credentials you currently hold. If you do not hold any, please circle "N/A" below.

1- Licensed Clinical Practitioner (LCP)
2- Licensed Clinical Social Worker (LCSW)
3- Advanced Clinical Practitioner (ACP)
4- Licensed Specialist in School Psychology (LSSP)
5- Licensed Chemical Dependency Counselor (LCDC)
6- Licensed Doctoral-level Psychologist
7- N/A

10. Including training (e.g. practicum and field placements) and work experiences (part or full time), how many years of one-on-one psychotherapy experience do you have?

1-1-3 years
2- 4-7 years
3- 8-11 years
4-12-15 years
5-16-18 years
6-19 years and beyond
7- Other _____

11. Have you in the past, or are you currently, seeing a therapist for group or individual therapy?

1-Yes
2-No

12. If you answered Yes, how many years have you been in therapy? (If you answered No, please leave this question blank).

1- 0-3 years
2- 4-7 years
3- 8-11 years
4- 12-15 years
5- 16-18 years
6- 19 years and beyond
7- Other _____

Appendix H

Brief Interview

What are the key principles or theoretical orientations which guide how you do therapy (when you are the therapist)?

What are some themes you see in many of your clients?

To the extent that interpersonal issues seem salient to your work as a therapist, can you speculate about life or training experiences that gave you this focus?

To the extent that achievement/self-definition issues seem salient to your work as a therapist, can you speculate about life or training experiences that gave you this focus?

Appendix I

Sample Form Used by Expert Judges to Rate Vignettes

Vignette #1

Please read the following paragraph and listen to the tape marked "Vignette #1". After you have listened to the vignette; please complete the following items in reference to the client you heard in vignette #1. Please put your answers directly on this sheet.

Lucille is a 23 year-old Caucasian female whom you have seen for five previous sessions. She is an undergraduate at The University of Texas at Austin studying music. Her parents are married and live in Dallas. Lucille transferred to UT to be with her ex-boyfriend, Zachary, and has been in several consecutive romantic relationships for the past 5 or so years. The majority of her therapy sessions have explored her current relationship with her boyfriend, Brad. She is distraught in this week's session, as Brad has abruptly ended the relationship.

On the following items, each characteristic is followed by a seven-point scale that ranges from "not very" to "very." Please mark an "X" at the point on the scale that best represents how you viewed the client in this vignette. For example:

FUNNY

Not very _X_: ___: ___: ___: ___: ___: very

This rating shows the client was not at all funny in the vignette. Though all of the following characteristics you will rate are desirable, clients may differ in these areas. I am interested in knowing how you view these differences.

FRIENDLY

Not very __: ___: ___: ___: ___: ___: very

LIKEABLE

Not very __: ___: ___: ___: ___: ___: very

SOCIABLE

Not very __: ___: ___: ___: ___: ___: very

WARM

Not very __: ___: ___: ___: ___: ___: very

Please rate the following statements using this 5-point Likert scale:

1 = not at all
2 = a little
3 = moderately
4 = much
5 = extremely

____ The client in this vignette relays her conflicts and problems in a realistic manner.
____ This vignette is an authentic and believable illustration of a client.
____ I can imagine seeing such a client.

Please read the following paragraphs and answer the questions below using the same 5-point Likert scale above:

Dependency or sociotropy refers to excessive reliance on interpersonal interactions that maintain self-esteem. The dependent or sociotropic person relies entirely on a significant other(s) to provide his or her sense of self worth and fulfillment The individual receives comfort through praise and punishment offered by an identified significant other and tends not to gain happiness independently. The dependent person forms a bargain relationship in which he/she forgoes independent gratification in return for the continued nurturance and support of the esteemed other.

_____ This client illustrates dependent or sociotropic personality as described above.

Self-criticism or autonomy refers to themes of personal achievement, excessive self-criticism, and relentless pursuit of goals. The self critical or autonomous individual attaches personal worth and life meaning to achievement of some high aspiration. These individuals believe attaining this goal will guarantee the adoration of others and will be life altering. Self-critical or autonomous individuals may experience alienation as a result of their fixation on personal success.

_____ This client illustrates self critical or autonomous personality as described above.

Appendix J

Please write down <u>three statements made by **Judy**</u> that come to your mind. Use the first three statements that you can think of. Do your best to recall the particular words and phrasing **Judy** used.

Judy is the second client you heard. Her guitar is in hock and she is studying music.

1.
2.
3.

<u>Please answer the following questions regarding **Judy:**</u>

	Not at all	Somewhat	Moderately	Very	Much
To what extent do you think it would be difficult to work with **Judy?**	1	2	3	4	
To what extent are you optimistic about the outcome of therapy with **Judy?**	1	2	3	4	
To what extent do you dislike **Judy?**	1	2	3	4	
To what extent do you feel affectionate toward **Judy?**	1	2	3	4	
To what extent does **Judy** make you feel anxious?	1	2	3	4	
To what extent does **Judy** make you feel bored?	1	2	3	4	

Please write down three statements made by **Margaret** that come to your mind. Use the first three statements that you can think of. Do your best to recall the particular words and phrasing **Margaret** used.

Margaret is the third client you heard. She is studying theater and dance, and makes mention of using the Internet.

1.
2.
3.

Please answer the following questions regarding **Margaret:**

	Not at all	Somewhat	Moderately	Very Much
To what extent do you think it would be difficult to work with **Margaret?**	1	2	3	4
To what extent are you optimistic about the outcome of therapy with **Margaret?**	1	2	3	4
To what extent do you dislike **Margaret?**	1	2	3	4
To what extent do you feel affectionate toward **Margaret?**	1	2	3	4
To what extent does **Margaret** make you feel anxious?	1	2	3	4
To what extent does **Margaret** make you feel bored?	1	2	3	4

Please write down three statements made by **Mary Ann** that come to your mind. Use the first three statements that you can think of. Do your best to recall the particular words and phrasing **Mary Ann** used.

Mary Ann is the fourth client you heard. Her parents are moving out-of-state. She has a roommate named Carrie who is also her best friend.

1.
2.
3.

Please answer the following questions regarding **Mary Ann:**

	Not at all	Somewhat	Moderately	Very Much
To what extent do you think it would be difficult to work with **Mary Ann?**	1	2	3	4
To what extent are you optimistic about the outcome of therapy with **Mary Ann ?**	1	2	3	4
To what extent do you dislike **Mary Ann?**	1	2	3	4
To what extent do you feel affectionate toward **Mary Ann?**	1	2	3	4
To what extent does **Mary Ann** make you feel anxious?	1	2	3	4
To what extent does **Mary Ann** make you feel bored?	1	2	3	4

Please write down <u>three statements made by **Terry**</u> that come to your mind. Use the first three statements that you can think of. Do your best to recall the particular words and phrasing **Terry** used.

Terry is the fifth client you heard. She works for a radio station and owns a dog.

1.
2.
3.

<u>Please answer the following questions regarding **Terry:**</u>

	Not at all	Somewhat	Moderately	Very Much
To what extent do you think it would be difficult to work with **Terry?**	1	2	3	4
To what extent are you optimistic about the outcome of therapy with **Terry ?**	1	2	3	4
To what extent do you dislike **Terry?**	1	2	3	4
To what extent do you feel affectionate toward **Terry?**	1	2	3	4
To what extent does **Terry** make you feel anxious?	1	2	3	4
To what extent does **Terry** make you feel bored?	1	2	3	4

Appendix K

Script of Instructions for the Vignette Portion of Procedure

The tape you are about to listen to you will give you specific instructions, however there are some things I would like to go over with you before you begin. When you are listening to these vignettes, please take the set of an actual therapist with the five different clients you are about to listen to. Please assume an ongoing counseling relationship with each client, in which initial rapport has been established. Pay close attention to your thoughts and feelings about the client while you are listening to each vignette.

If you notice you have time left over or some silences after finishing your written questions or verbal responses, do not worry, everyone takes different amounts of time to complete each task. Also, when giving your verbal responses to the client, we are most interested in your first reactions, not so much your language or how eloquently you respond. Your verbal responses will be kept confidential and will only be identified by a code you will assign to yourself later on in the study.

This portion of the study should take about 40 minutes. Please come get me when you have finished the tape. I will be present in the room for the first vignette to get you started and then I will leave. Any questions? Start tape. that they were not expected to provide a verbal response when prompted and that silences were acceptable. Participants were told to provide responses as if they were speaking directly to the client.

Participants were also told to adjust the volume on the audio tape player as needed and to disconnect telephones in the room.

Appendix L

Verbal Response Coding Form

SUBJECT #_____ FORM _____

CODER'S INITIALS_____

Dependency or sociotropy refers to excessive reliance on interpersonal interactions that maintain self-esteem. The dependent or sociotropic person relies entirely on a significant other(s) to provide his or her sense of self worth and fulfillment The individual receives comfort through praise and punishment offered by an identified significant other and tends not to gain happiness independently. The dependent person forms a bargain relationship in which he/she forgoes independent gratification in return for the continued nurturance and support of the esteemed other.

Self-criticism or autonomy refers to themes of personal achievement, excessive self-criticism, and relentless pursuit of goals. The self critical or autonomous individual attaches personal worth and life meaning to achievement of some high aspiration. These individuals believe attaining this goal will guarantee the adoration of others and will be life altering. Self-critical or autonomous individuals may experience alienation as a result of their fixation on personal success.

VIGNETTE # __

Response 1:

On a scale from 1 to 6, how much does the therapist's response help the client explore **dependency** issues?

Not at all 1 2 3 4 5 6 Very much

On a scale from 1 to 6, how much does the therapist's response help the client explore **self-criticism** issues?

Not at all 1 2 3 4 5 6 Very much

Response 2:

On a scale from 1 to 6, how much does the therapist's response help the client explore **dependency** issues?

Not at all 1 2 3 4 5 6 Very much

On a scale from 1 to 6, how much does the therapist's response help the client explore **self-criticism** issues?

Not at all 1 2 3 4 5 6 Very much

Overall, how much does the therapist like the client in this vignette?

Does not like 1 2 3 4 5 6 Likes very much

Appendix M

Cognitive Recall Coding Form

1. On a scale from 1 to 6, how much does the recalled words/phrase reflect **dependency or sociotropic content?**

1 2 3 4 5 6

On a scale from 1 to 6, how much does the recalled words/phrase reflect **self-criticism or autonomous content?**

1 2 3 4 5 6

2. On a scale from 1 to 6, how much does the recalled words/phrase reflect **dependency or sociotropic content?**

1 2 3 4 5 6

On a scale from 1 to 6, how much does the recalled words/phrase reflect **self-criticism or autonomous content?**

1 2 3 4 5 6

3. On a scale from 1 to 6, how much does the recalled words/phrase reflect **dependency or sociotropic content?**

1 2 3 4 5 6

On a scale from 1 to 6, how much does the recalled words/phrase reflect **self-criticism or autonomous content?**

1 2 3 4 5 6

Appendix N

Questions Regarding Attitudes Towards Goals for Treatment

Please answer the following questions about **Terry.** To remind you, **Terry** is the second client you heard. She works for a radio station and owns a dog.

To what extent do you think **Terry's** interpersonal or dependency issues are important to focus on in therapy?

Not at all important Somewhat important Moderately important Very important
1 2 3 4

To what extent do you think **Terry's** achievement or self-definition issues are important to focus on in therapy?

Not at all important Somewhat important Moderately important Very important
1 2 3 4

Please answer the following questions about **Mary Ann.** To remind you, **Mary Ann** is the third client you heard. Her parents are moving out-of-state. She has a roommate named Carrie who is also her best friend.

To what extent do you think **Mary Ann's** interpersonal or dependency issues are important to focus on in therapy?

Not at all important Somewhat important Moderately important Very important
1 2 3 4

To what extent do you think **Mary Ann's** achievement or self-definition issues are important to focus on in therapy?

Not at all important Somewhat important Moderately important Very important
1 2 3 4

Please answer the following questions about **Margaret.** To remind you, **Margaret** is the fourth client you heard. She is studying theater and dance, and makes mention of using the Internet.

To what extent do you think **Margaret's** interpersonal or dependency issues are important to focus on in therapy?

Not at all important	Somewhat important	Moderately important	Very important
1	2	3	4

To what extent do you think **Margaret's** achievement or self-definition issues are important to focus on in therapy?

Not at all important	Somewhat important	Moderately important	Very important
1	2	3	4

Please answer the following questions about **Judy.** To remind you, **Judy** is the fifth client you heard. Her guitar is in hock and she is studying music.

To what extent do you think **Judy's** interpersonal or dependency issues are important to focus on in therapy?

Not at all important	Somewhat important	Moderately important	Very important
1	2	3	4

To what extent do you think **Judy's** achievement or self-definition issues are important to focus on in therapy?

Not at all important	Somewhat important	Moderately important	Very important
1	2	3	4

Appendix O

Informed Consent Form -Therapists

(The University of Texas at Austin Version)

Investigator: Jennifer Vane, MA (512) 445-2155, jvane@mail.utexas.edu
Faculty Supervisor: Stephanie Rude, Ph.D. (512) 471-4409, stephanie.rude@mail.utexas.edu

Today we are trying to develop an understanding of therapists' reactions to clients. This study is being completed for the investigator's dissertation research. You have been asked to participate in this study as you are currently or have been a therapist or therapist in training; and have at least one-year individual therapy experience. Approximately 50 to 100 professionals and/or graduate students in school, clinical, counseling psychology, counselor education, and social work will participate in this study.

The Department of Educational Psychology and the University of Texas at Austin requires that all persons who participate in psychological studies give their written consent to do so. We want you to understand that your participation in this study is completely voluntary, and that you are free to choose not to participate and/or not answer every question in the study. If you do decide to participate you may withdraw at any time during the study. Your decision not to participate or your decision to withdraw during the study will not result in any penalty, academic or otherwise.

Confidentiality

Your responses in this experiment will be anonymous and kept confidential to the maximum extent possible. You will be asked to create your own participant identification number. Your materials will be identifiable using only this information. Every effort will be made to ensure that any verbal, written, or behavioral responses you give during this study will be known only to the experimenter and her faculty advisor. Faculty and/or fellow students will not be allowed to learn of your responses. Some of your responses will be audiotaped. Your taped responses will only be identified by the participant identification number you provide, and will be transcribed and destroyed at the conclusion of the project. Audiotapes will be kept under lock by the investigator.

Potential Risks

The methods or procedures in this study are neither dangerous nor harmful, but they may be experienced by some people as uncomfortable (e.g. you may be asked personal questions or be asked to recall unpleasant emotions). If you experience emotional distress at the conclusion of this study, please inform the investigator.

Potential Benefits

You may gain increased insight surrounding your own reactions to clients, and how your personality and life experiences influence your work as a therapist. You may also contact the investigator for participation or assistance with your research projects.

Description of Study

You will be asked to listen to audiotaped case vignettes and provide written and verbal responses to each vignette. Additionally, you will complete three self-report measures and a brief one-on-one interview. This study will take approximately 1 and 1/2 hours to complete.

If after reading the above information you decide to participate in the study, please sign below to indicate that you understand all of the above information and that you give your consent to participate in the study as it is described. Please feel free to ask the experimenter any questions you may have before or after signing this consent form. The experimenter will be happy to give you a copy of this consent form if you so desire.

_____ _____

Signature Date

Appendix P

INFORMED CONSENT - Therapist Study

(University of Houston Version)

Investigator: Jennifer Vane, MA
Faculty Supervisor(s): Ken Waldman, Ph.D.

You are being invited to participate in a study conducted by Jennifer Vane, psychology intern at the University of Houston Counseling and Psychological Services. Today we are trying to develop an understanding of therapists' reactions to clients. This study is being completed for the investigator's dissertation research. You are invited to participate in this study as you are currently or have been a therapist or therapist in training; and have at least one-year individual therapy experience. Approximately 50 to 100 professionals and/or graduate students in school, clinical, counseling psychology, counselor education, and social work from Houston and Austin are invited to participate in this study. Forty subjects from Austin, Texas participated from June 2001 to August 2001, and the investigator is inviting additional subjects from Houston to participate from November 2001 to February 2002. The results of this study may be published in professional and/or scientific journals. It may also be used for educational purposes or for professional presentations. However, no individual subject will be identified.

Informed consent is required of all persons who participate in research studies. We want you to understand that if you decide to participate in this study, your participation is completely voluntary, and you are free to choose not to participate and/or not answer every question in this study. If you do decide to participate, you may withdraw at any time during the study. Your decision not to participate or your decision to withdraw during the study will not result in any penalty against you, academic or otherwise. Your decision not to participate or your decision to withdraw during the study will also not affect, in any way, your employment status at the University of Houston.

Description of Study

If you agree to participate in this study, you will be asked to listen to audio taped case vignettes and provide written and verbal responses to each vignette. Following the vignettes, you will complete three self-report measures, a demographic questionnaire, and a brief one-on-one interview. This study will take approximately 1 and 1/2 hours to complete if you choose to participate.

Confidentiality

If you decide to participate in this study, your responses in this experiment will be kept confidential to the maximum extent possible. If you decide to participate, you will be asked to create your own participant identification number. Your materials will be identifiable using only the number you assign to them. Your name will appear only at the bottom of this consent form, and this form will be kept under lock and key separate from all of your responses to this study. The investigator will have no way of matching your name to your research materials. ALL RESEARCH MATERIALS AND SUBJECT RESPONSES WILL BE STORED AT THE HOME OF THE INVESTIGATOR AND NOT AT THE UNIVERSITY OF HOUSTON. THE INVESTIGATOR'S FACULTY SPONSOR WILL HAVE NO ACCESS TO YOUR RESPONSES.

Every effort will be made to ensure that any verbal, written, or behavioral responses you give during this study will be known only to the experimenter and her two qualified graduate assistants. Faculty and/or fellow students will not be allowed to learn of your responses. Some of your responses will be audio taped. Your taped responses will only be identified by the participant identification number you provide, and your name will not appear in any form (written or spoken) on the audiotape. Audiotapes will be stored under lock and key in the investigator's home. These tapes will be coded by the investigator's two graduate assistants and will be destroyed at the conclusion of this project in spring 2001.

Potential Risks

The methods or procedures in this study are neither dangerous nor harmful, but some of the material may be regarded as sensitive and/or distressing. For example, if you decide to participate you will be asked to respond to multiple choice questions such as:

> I worry that I'm developing a serious illness, even though nothing serious has been diagnosed by a physician.
> I worry a lot about the bad things happening in the world: crime, pollution, and so on.
> If I disappeared tomorrow, no one would notice.

If you decide to participate in this study and you experience emotional distress at the conclusion of the experiment, please inform the investigator. You may also contact one of the following counseling agencies should you experience emotional distress following participation in this study, should you decide to participate:

Baylor Psychiatroic Clinic - Adult Outpatient Clinic (713) 798-4856
Counseling Services of Houston (713) 521-9391
Houston/Galveston Institute (713) 526-8390
Houston Psychological Association (713) 621-0131
Family Service Center (713) 861-4849
Psychological Research and Services Center (713) 743-8600
University of Texas Mental Sciences Institute-Adult Clinic (713) 500-2700

Potential Benefits

If you decide to participate, you may gain increased insight surrounding your reactions to clients, and how your personality and life experiences influence your work as a therapist. You may also contact the investigator for participation or assistance with your research projects.

If after reading the above information you decide to participate in this study; please sign below to indicate that you understand all of the above information and that you give your consent to participate in the study as it is described. Please feel free to ask the experimenter any questions you may have before or after signing this consent form. The experimenter is happy to give you a copy of this consent form if you so desire.

ANY QUESTIONS REGARDING YOUR RIGHTS AS A RESEARCH SUBJECT MAY BE ADDRESSED TO THE UNIVERSITY OF HOUSTON COMMITTEE FOR THE PROTECTION OF HUMAN SUBJECTS (713) 743-9204. ALL RESEARCH POJECTS THAT ARE CARRIED OUT BY INVESTIGATORS AT THE UNIVERSITY OF HOUSTON ARE GOVERNED BY REQUIREMENTS OF THE UNIVERSITY AND THE FEDERAL GOVERNMENT.

_____	_____	_____
Printed Name	Signature	Date

Appendix Q

Debriefing Form

The purpose of this study is to explore countertransference from a schema theory perspective, specifically dependency and self-criticism schemata in therapists. "*Dependency" or "sociotropy"* refers to reliance on interpersonal interactions to maintain self-esteem. A person high in dependency or sociotropic traits tends to rely on significant other(s) to provide his or her sense of self worth and fulfillment. The individual receives comfort only through praise and punishment offered by identified significant other(s) and does not tend to gain happiness independently. *"Autonomy" or "self-criticism"* refers to themes of personal achievement, excessive self-criticism, and relentless pursuit of goals. A person high in self-criticism or autonomous traits tends to attach personal worth and life meaning to achievement of some high aspiration. These individuals believe attaining this goal will guarantee the adoration of others and will be life altering. Depression vulnerability research has given the most attention to these schemata, and more current research is examining these constructs as they relate to interpersonal problems in adolescents, everyday social interactions among college students, selection of romantic partners in college students, and attachment styles in "normal" populations. Surprisingly, no known research has examined these specific personality characteristics or schemata in therapists, and how these kinds of schemata may interact with client issues to influence therapists' verbal responses to clients, affective arousal, and cognitive resources in therapy. This dissertation examines therapists' affective arousal, cognitive resources, and verbal responses in reaction to clients' dependency and self-criticism issues as a function of therapists' own dependency or self-criticism schemata. If you would like specific feedback regarding your participation in this study, please record your participant identification number and contact Jennifer Vane at jvane@mail.utexas.edu. Thank you again for your participation, and please do not hesitate to contact the investigator in the future.

PLEASE DO NOT DISCUSS THE NATURE OF THIS STUDY
WITH OTHER STUDENTS!

Appendix R

Correlations among Young's EMS, PSI Sociotropy, PSI Autonomy, and BSI Total

EMS	Sociotropy	Autonomy	BSI Total
Emotional Deprivation	.30*	.36*	.58****
Abandonment	.61****	.40**	.63****
Mistrust/Abuse	.41**	.59****	.54****
Social Isolation/Alienation	.44**	.55****	.72****
Defectiveness/Shame	.40**	.55****	.53****
Social Undesirability	.35*	.26	.35*
Failure	.39**	.47***	.70****
Dependence/Incompetence	.41**	.45**	.68****
Vulnerability to Harm/Illness	.48***	.49***	.74****
Enmeshment	.40**	.35*	.44**
Subjugation	.57****	.42**	.68****
Self-Sacrifice	.45**	.43**	.37**
Emotional Inhibition	.36*	.46***	.75****
Unrelenting Standards	.35*	.49***	.26
Entitlement	.25	.50***	.33*
Insufficient Self-Control/	.46**	.57****	.65****

Self-Discipline			
PSI Sociotropy	1.00	.59****	.39**
PSI Autonomy	.59****	1.00	.46***

Note: p* < .05; p** < .01; p*** < .001; p**** < .0001.

Appendix S

Comparison of Pearson Correlational Coefficients for Total BSI Score, Therapists' Age, Professional Experience, Years of Personal Therapy, and Independent Variables Entered in Regression Analyses.

	BSI TOTAL	SELF-CRITICAL SCHEMAS	DEPENDENCY SCHEMAS	AGE	YEARS OF EXPERIENCE	YEARS OF THERAPY
BSI TOTAL	1.0	.68**	.71**	.20	.37**	-.02
SELF-CRITICAL SCHEMAS	.68**	1.0	.75**	.23	.40**	.02
DEPENDENY SCHEMAS	.71**	.75**	1.0	.22	.20	-.12
AGE	.20	.23	.22	1.0	.32*	-.16
YEARS OF EXPERIENCE	.37**	.40**	.20	.32*	1.0	.01
YEARS OF THERAPY	-.02	.02	-.12	-.16	.01	1.0

Appendix T

Correlations among Independent and Dependent Variables Entered in Regression Analyses

Dependent Variable	Dependency Schemas	Self-Criticism Schemas
Anxiety in Response to Dependency Vignettes	.23	.15
Anxiety in Response to Self-Criticism Vignettes	.23	.13
Cognitive Recall for Dependency Vignettes	-.30*	-.16
Cognitive Recall for Self-Criticism Vignettes	-.33*	-.27
Exploration of Dependency Content	-.37**	-.39**
Exploration of Self-Criticism Content	-.14	-.17
Improvement Estimate for Dependency Vignettes	-.13	-.11
Improvement Estimate for Self-Criticism Vignettes	-.04	.02
Importance of Dependency Treatment Issues	-.35*	-.23
Importance of Self-Criticism Treatment Issues	.07	-.04
Warmth/Liking/Affection for Dependency Vignettes	-.05	-.16
Warmth/Liking/Affection for Self-Criticism Vignettes	-.05	-.08

Note: p* < .05; p** < .0

Appendix U

Comparison of Pearson Correlational Coefficients for Total BSI Score, Dependent Variables, Age, Professional Experience, and Years of Personal Therapy.

	Age	Total BSI	Years Exp.	Years Therapy	Total Anxiety Dependency	Total Anxiety Self-Criticism	Warmth/Like Dependency	Warmth/Like Self-Criticism
Age	1	0.2	.32*	-.16	.03	.06	.11	-.04
Total BSI	0.2	1	.37**	-.02	.29*	.18	-.11	-.10
Years of Experience	.32*	.37**	1	.01	-.08	-.07	-.04	-.05
Years Therapy	-0.16	-.02	.01	1	-.037	-.11	-.04	.13
Total Anxiety Dependency	.03	.29*	-.08	-.04	1	.83**	-.37**	-.22
Total Anxiety Self-Criticism	.06	.18	-.07	-.11	.83**	1	-.16	-.15
Warmth/Like Dependency	.11	-.11	-.04	-.04	-.37**	-.16	1	.62**
Warmth/Like Self-Criticism	-.04	-.10	-.05	.13	-.22	-.15	.62**	1
Importance of Dependency Issues	-.23	-.41**	-.31*	-.001	-.05	.07	.09	.13
Importance of Self-Criticism Issues	-.29*	-.30*	-.17	.15	-.12	-.19	-.03	.12
Improvement/ Outcome Dependency	.04	-.06	.06	.18	-.34	-.26	.42**	.27
Improvement/ Outcome Self-Criticism	-.03	.08	.15	.23	-.39**	-.53**	.18	.39**
Verbal Exploration of Dependency Issues	-.18	-.37**	-.14	.07	-.09	-.002	.37**	.25
Verbal Exploration of S. Criticism	-.01	-.08	.05	-.07	-.13	-.09	.26	.15

	Importance of Self-Criticism Issues	Improvement Outcome Dependency	Improvement Outcome Self-Criticism	Verbal Exploration Dependency	Verbal Exploration S. Criticism
Age	-.29*	.04	-.03	-.18	-.005
Total BSI	-.30*	-.06	.08	-.37**	-.08
Years of Experience	-.17	.06	.15	-.14	.05
Years Therapy	.15	.18	.23	.07	-.07
Total Anxiety Dependency	-.12	-.34*	-.39	-.09	-.13
Total Anxiety Self-Criticism	-.19	-.26	-.53**	-.002	-.09
Warmth/Like Dependency	-.03	.42**	.18	.37**	.26
Warmth/Like Self-Criticism	.12	.27	.39**	.25	.15
Importance of Dependency Issues	.65**	.007	-.11	.24	-.07
Importance of Self-Criticism Issues	1	-.05	.20	.08	.11
Improvement/ Outcome Dependency	-.05	1	.64**	.15	.33*
Improvement/ Outcome Self-Criticism	.20	.64**	1	-.04	.23
Verbal Exploration of Dependency Issues	.08	.15	-.04	1	.20
Verbal Exploration of S. Criticism	.11	.33*	.23	.20	1

Appendix V

Nonsignificant Results of Linear Regression Analyses for Dependency Schemata Predicting Therapists' Countertransferential Responses to Dependency Vignettes (N=50)

Dependent Variable	R Square	F	p
Outcome/Improvement	.02	.78	.38
Warmth/Liking/Affection	.002	.10	.75
Total Anxiety	.05	2.53	.12

Appendix W

Nonsignificant Results of Linear Regression Analyses for Self-Criticism Schemata Predicting Therapists' Countertransferential Responses to Self-Criticsm Vignettes (N = 50)

Dependent Variable	R Square	F	p
Cognitive Recall of Self-Criticism Content	.03	1.29	.26
Outcome/ Improvement for Self-Criticism Vignettes	.00	.02	.90
Total Anxiety	.02	.84	.37
Verbal Exploration of Self-Criticism Content	,03	1.33	.25
Warmth/Liking/Affection	.01	.25	.62

Appendix X

Nonsignificant Results of Linear Regression Analyses for Self-Criticism Schemata Predicting Therapists' Countertransferential Responses to Dependency Vignettes

Dependent Variable	R Square	F	p
Cognitive Recall of Dependency Content	.00	.01	.94
Importance of Dependency Treatment Issues	.05	2.60	.11
Outcome/ Improvement for Dependency Vignettes	.01	.59	.45
Total Anxiety	.02	.99	.32
Warmth/Liking/Affection	.03	1.21	.28

Appendix Y

Nonsignificant Results of Linear Regression Analyses for Dependency Schemata Predicting Therapists' Countertransferential Responses to Self-Criticism Vignettes (N=50)

Dependent Variable	R Square	F	p
Cognitive Recall of Self-Criticism Content	.04	1.90	.18
Importance of Self-Criticism Treatment Issues	.08	4.10	.05
Outcome/ Improvement for Self-Criticism Vignettes	.00	.09	.77
Total Anxiety	.05	2.60	.11
Verbal Exploration of Self-Criticism Content	.02	.97	.33
Warmth/Liking/Affection	.00	.11	.74

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Vita

Jennifer Dale Vane was born on August 1, 1972 in Houston, Texas, the daughter of Richard J. Vane and Sue Rosenbloom Vane. Jennifer graduated from Bellaire High School and entered The University of Texas at Austin in fall1990. As an undergraduate psychology major, Jennifer developed her first interests in cognitive theory and anxiety disorders as an undergraduate research assistant. After completing her B.A. in Psychology in 1994, Jennifer attended Southern Methodist University in Dallas, Texas, where she completed a Master of Arts degree in Clinical/Counseling Psychology under the direction of Dr. Marjorie Hatch. While at Southern Methodist University, Jennifer completed a thesis exploring family atmosphere, obsessive compulsive characteristics, and self-esteem in Jewish families, which was later published in the Journal of Psychology and Judaism. Jennifer entered the Counseling Psychology Doctoral Training Program at The University of Texas at Austin in the fall of 1997, and enthusiastically began what would be a most challenging and fulfilling era. In her doctoral program, Jennifer worked with Dr. Stephanie Rude on several projects exploring cognitive theory and depression, one of which was later published in Cognition and Emotion. Through her research and clinical experiences, Jennifer developed an interest in exploring countertransference from a schema-theory perspective. Following her pre-doctoral internship at the University of Houston Counseling and Psychological Services Center and graduation from The University of Texas at Austin, Jennifer will be completing a post-doctoral fellowship at the University of Southern California Student Counseling Services and Disability Services and Programs. Jennifer hopes

to devote her career to therapy, assessment, supervision, and training in university counseling centers, and will continue to investigate the role of self-schemata in predicting therapists' countertransferential reactions, efficacy, and treatment outcomes.

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