Therapist Mindfulness and Effective Therapeutic Relating: Exploring the Mediating Role of Countertransference Management

By

Maggie C. Sampe

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The dissertation is approved by the following members of the Final Oral Committee:

Mindi N. Thompson, Professor, Counseling Psychology
William T. Hoyt, Professor, Counseling Psychology
Simon B. Goldberg, Assistant Professor, Counseling Psychology
Stephanie R. Graham, Clinical Associate Professor, Counseling Psychology
Shanna Murray, Staff Psychologist, Clinical Psychology

Abstract

Therapist effects and the relationship between client and therapist have been demonstrated to be powerful predictors of psychotherapy treatment outcomes (Beutler et al., 2003; Duncan, 2010; Wampold & Brown, 2005). The proposed study sought to expand this body of literature by focusing on therapist mindfulness and its relation to the therapeutic relationship. Using the tripartite model of the therapeutic relationship proposed by Gelso and Carter (1985, 1994) as a theoretical framework, relations among therapist mindfulness, meditation experience, countertransference management, the working alliance, and real relationship between client and therapist were explored. Seventy-seven dyads comprised of therapists in training and their supervisors participated. Therapists in training completed self-report measures assessing trait mindfulness, prior meditation experience, and ratings of the real relationship and working alliance for three clients they saw for individual psychotherapy in the past week and with whom they had met for a minimum of five sessions. Supervisors provided ratings of trainee countertransference management ability. Consistent with theory and prior research findings, results demonstrated positive associations among therapist mindfulness, countertransference management, the real relationship, and the working alliance. Evidence for the moderating effects of prior meditation experience was found such that meditation experience strengthened the positive relationships between therapist self-reported mindfulness and supervisor ratings of countertransference management; therapist self-reported mindfulness and therapist ratings of the real relationship, and therapist self-reported mindfulness and therapist ratings of the working alliance. Contrary to hypothesized expectations, countertransference did not mediate the relationship between therapist self-reported mindfulness and therapist ratings of the real and

working alliance. Study strengths and limitations along with implications for clinical practice, training, and supervision are discussed

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Chapter I

Statement of the Problem

Psychotherapy has been conceptualized as a social healing practice, such that "psychotherapy utilizes human propensities to help clients change" (Wampold & Imel, 2015, p. 21). In support of this conceptualization, findings from psychotherapy process and outcome research have demonstrated that the relationship between therapist and client is essential to therapeutic change (Elkins, 2012). Scholars (e.g., Elkins, 2012) have recommended that clinical training focus on helping trainees to relate more effectively with their clients. However, exactly how trainees are to acquire the necessary intra- and interpersonal competencies remains unclear (Fatter & Hayes, 2013). To this end, mindfulness and mindfulness meditation have been proposed as a means to enhance therapeutic relating (Bruce et al., 2010; Lambert and Ogles, 2004; Shapiro & Carlson, 2009). Specifically, theorists (e.g., Bruce et al., Siegel, 2007a, 2012) have suggested that mindfulness may promote the ability to manage and use countertransference reactions in order to advance the work of therapy; however, this hypothesis has been largely untested. The current study sought to advance a humanistic understanding of psychotherapy by investigating the connections among mindfulness meditation, therapist mindfulness, countertransference management, and two fundamental aspects of the therapeutic relationship: the 'real' relationship and the working alliance.

The Tripartite Model of the Therapeutic Relationship

Despite growing empirical interest in the therapeutic relationship, there have been few efforts to clearly define and identify its essential components. Early humanistic theorists equated the therapeutic relationship with the therapist offered conditions of empathic understanding, unconditional positive regard, and congruence (Rogers, 1957, 1975; Patterson, 1984). General

working definitions described the therapeutic relationship as the feelings and attitudes clients hold toward one another and the manner in which these are expressed (Gelso & Carter, 1985). More recently, the working alliance between client and therapist has been used as a proxy for the therapeutic relationship. The current study conceptualizes the therapeutic relationship based upon Gelso and Carter's (1985; 1994) tripartite model of the therapeutic relationship.

The Gelso and Carter (1985, 1994) tripartite model of the therapeutic relationship posits that all psychotherapy relationships, regardless of therapist theoretical orientation, consist of three interlocking elements: a 'real' relationship, a working alliance, and a transference configuration (Gelso, 2014; Gelso & Carter, 1985, 1994). Theoretically, the components of the therapeutic relationship are both interrelated and distinct; each component influences the others as well as the process and outcome of therapy. All three components of the therapeutic relationship are present from the first contact between client and therapist; however, the salience and importance of each aspect may fluctuate over the course of therapy in meaningful and predictable ways.

The Real Relationship

Gelso and Carter (1985, 1994) identify the real relationship as the foundation of the therapeutic relationship, such that it is a universal part of every therapeutic interaction. The real relationship is defined as the personal relationship between therapist and client, marked by the extent to which each is genuine with the other and perceives/experiences the other in ways that befit the other (Gelso & Carter, 1985, 1994). Accordingly, two defining features best characterize the real relationship: genuineness and realism (Gelso & Carter, 1985, 1994; Greenson, 1967). Genuineness is defined as the ability and willingness to be authentic, open, and honest. Realism refers to accurate, reality-based perceptions of the other. Theoretical

conceptualizations of the real relationship have been further refined to include the magnitude and valence of both genuineness and realism such that greater magnitude and more positivity are indicative of a stronger real relationship.

The Working Alliance

The real relationship is the foundation of the overall therapeutic relationship and the working alliance emerges from the real relationship and directly facilitates the work of psychotherapy. The working alliance is defined as the alignment or joining together of the reasonable self or ego of the client and the therapist's analyzing or 'therapizing' side for the purpose of the work (Gelso & Carter, 1994). In the face of emotional obstacles and resistance, it is the joining of client and therapist that "allows each to observe, understand, and do the work of psychotherapy" (Gelso, 2011, p. 8). Bordin's (1979) conditions for an effective alliance are thus realized: the therapist and client experience a working bond, they agree (implicitly or explicitly) on the goals of therapy and believe these to be attainable, and they agree on the tasks that will help attain those goals. Within the tripartite model, the development of a "good enough" working alliance is vital to the success of all therapy.

The Transference Configuration

The transference configuration consists of both client transference and therapist countertransference. Integrating classical conceptualizations of transference as projected distortion with more contemporary and relational conceptualizations, transference is defined as the client's experience and perceptions of the therapist that are shaped by the client's personal history and related psychological structures (Gelso & Hayes, 1998). In effect, transference involves the displacement of feelings, attitudes, and behaviors from significant early relationships onto the therapist (Gelso & Hayes, 1998; Gelso & Bhatia, 2012). Although the

concept of transference has roots in psychoanalytic theory, the tripartite model identifies transference as a universal phenomenon, occurring across diverse theoretical perspectives (Gelso, 2014).

Likewise, therapist countertransference is seen as a transtheoretical process defined as the therapist's internal and external reactions to the client that are shaped by the therapist's past and present emotional conflicts and vulnerabilities (Gelso & Hayes, 2007). Countertransference may be conscious or unconscious and may occur in response to transference or other clinically relevant material. Known as the countertransference interaction hypothesis, triggers for countertransference reactions emerge out of the interaction between client behavior and therapist emotional conflicts and vulnerabilities (Gelso, 2014). As all therapists, by virtue of their humanity, have unresolved conflicts, personal vulnerabilities, and unconscious "soft spots," countertransference is both inevitable and highly idiosyncratic (Hayes, Gelso, & Hummel, 2011). Within the tripartite model of the therapeutic relationship, countertransference reactions may be beneficial, neutral, or destructive to the therapy, depending on their nature, valence, how they are dealt with by the therapist, and the central thrust of the therapy (Gelso & Carter, 1994).

Countertransference Management

In large part, the effects of countertransference, for good or for bad, depend upon how well the therapist is able to identify, understand, and manage their internal reactions to the client (Gelso & Hayes, 2007; Hayes, Gelso, Van Wagoner & Diemer, 1991). If countertransference is poorly understood and managed, it can spill into the session and impede the therapy (Gelso & Hayes, 2001; Gelso & Hayes, 2007; Hayes & Gelso, 1993; Hayes et al., 1998; Hayes, Riker, & Ingram, 1997; Ligiero & Gelso, 2002; Pope & Tabachnick, 1993; Rosenberger & Hayes, 2002a; Van Wagoner, Gelso, Hayes, Diemer, 1991). Unmanaged countertransference can lead to

therapists avoiding client content, overly involving themselves with client issues, and recalling client content differently than how it was actually discussed during the therapy session (Gelso & Hayes, 2007). Other behavioral manifestations of countertransference include therapists ignoring, blaming, or rejecting clients (Gelso & Hayes, 2007).

Research suggests that when therapists act out their negative countertransference, the working alliance is weakened (Gelso & Hayes, 2001; Ligiero & Gelso, 2002). Positive countertransference (e.g., too much support, colluding with the client), as rated by both supervisors and therapists in training, has similarly been associated with more superficial psychotherapy sessions and a weaker working alliance (Ligiero & Gelso, 2002; Markin, McCarthy, & Barber, 2013). Among clinical cases rated by supervisors and therapists as less successful, Hayes et al. (1997) found a strong negative relationship between countertransference behavior and treatment outcome.

Countertransference reactions, however, can also advance the work of therapy, so long as the therapist seeks to understand and use countertransference therapeutically (Hayes, Yeh, & Eisenberg, 2007). In order to manage and use countertransference therapeutically, the therapist must cultivate a set of skills and qualities that will allow them to harness reactions to clients, to be vigilant to protect against the possibility of acting on these reactions in injurious ways, and to derive clinically meaningful insights from these reactions. Thus, managing countertransference is theorized to be about more than simply controlling countertransference reactions. It includes reducing the likelihood that countertransference will occur, repairing any damage that results if and when countertransference is acted out during therapy, and using countertransference to advance the work (Gelso & Hayes, 2007).

Several therapist qualities have been theorized to facilitate countertransference management, namely: self-insight, conceptualizing ability, empathy, self-integration, and anxiety management (Gelso & Hayes, 2007; Hayes et al., 1991; Van Wagoner et al., 1991). *Self-insight* is defined as the therapist's awareness and understanding of their thoughts, feelings, behaviors, sensations, motives, and histories (Perez-Rojas et al., 2017). *Conceptualizing ability* refers to the therapist's use of theory to understand the client and the dynamics of the therapeutic relationship (Perez-Rojas et al., 2017). *Empathy* is the ability to grasp intellectually and, to a degree, feel what the client feels within the client's frame of reference (Perez-Rojas et al., 2017). *Self-integration* refers to the therapist's psychological health, which encompasses a sound sense of self and boundaries within the therapeutic relationship, and the ability to prioritize the client's needs over the therapist's own needs (Perez-Rojas et al., 2017). Finally, *anxiety management*, is the ability to modulate anxiety and to understand its origins (Perez-Rojas et al., 2017). Anxiety management holds prominence within countertransference management because anxiety is considered the most basic emotional state against which psychological defenses and by extension, countertransference reactions develop (Gelso, 2014; Perez-Rojas et al., 2017).

These five therapist qualities make up constituents of countertransference management and can be grouped into two dimensions: *understanding of the self and client* and *personal security* (Perez-Rojas et al., 2017). Self-insight, conceptualizing ability, and empathy are subsumed under *the understanding of the self and client* dimension and self-integration and anxiety management under the dimension of *personal security*. An *understanding of the self and the client* requires a combined understanding of the therapist's inner experience in relation to the client's experience as well as a conceptual understanding of the client's and the therapist's roles in the therapeutic process. *Personal security* stipulates a sense of psychological stability and

safety within the self of the therapist, which may buffer against threats to boundaries and difficult inner experiences in psychotherapy.

Countertransference Management Among Therapists in Training

Early research investigating countertransference management found that self-insight, conceptualizing ability, empathy, self-integration, and anxiety management distinguish excellent from average therapists (Van Wagoner et al., 1991). Therapists in training who possess more of these characteristics, as rated by their supervisors, demonstrated better treatment outcomes (Gelso, Latts, Gomez, & Fassinger, 2002). This is important because evidence suggests that therapists in training struggle with managing intense reactions to clients (Hill, Sullivan, Knox & Schlosser, 2007; Williams, Judge, Hill, & Hoffman, 1997). Specifically, therapists in training identified anxiety about seeing clients, troubling reactions toward clients, difficulties empathizing with clients, and problems related to self-awareness as significant challenges in the process of becoming a psychotherapist (Hill et al., 2007).

Due to their inexperience, therapists in training, in particular, may be more vulnerable to act out towards their clients based upon their countertransference responses (Howard, Inman, & Altman, 2006). Indeed, research suggests that therapists in training often lack many of the skills necessary to effectively manage countertransference, let alone use countertransference therapeutically (Hill et al., 2007). Based upon these findings, scholars have suggested that therapists in training must develop countertransference management skills (Fatter & Hayes, 2013; Hayes et al., 1991; Van Wagoner, Gelso, & Hayes, 1991). The question remains, however, as to *how* therapists in training might develop constituents of effective countertransference management (Fatter & Hayes, 2013). To this end, mindfulness has been proposed as a potential way to develop the qualities associated with effective therapeutic relating

and with countertransference management in particular (Bruce et al., 2010; Lambert and Ogles, 2004).

Mindfulness and the Therapeutic Relationship

Mindfulness has been defined as "the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience" (Kabat-Zinn, 2003, p. 145). Thus, mindfulness can be understood as both a process (mindful practice) and an outcome (mindful awareness; Shapiro & Carlson, 2009). It is posited to be an innate human capacity and way of relating to all experience with curiosity, openness, acceptance, and warmth (Lau et al., 2006; Shapiro & Carlson, 2009). The capacity for mindfulness (i.e., dispositional or trait mindfulness) has been conceptualized as a multidimensional construct characterized by five different facets: 1) observing; 2) describing; 3) acting with awareness; 4) being non-judging of inner experience; and 5) being non-reactive to inner experience (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006; Baer et al., 2008).

The capacity for mindfulness can be systematically cultivated through mindfulness meditation (Bodhi, 2000; Germer, 2005; Germer, Siegel, & Fulton, 2005; Wallace, 2001; Young, 1997). Mindfulness meditation is the formal practice of observing and shaping the mind with the mind. Specifically, it refers to "the development of skills such as greater ability to direct and sustain one's attention, less reactivity, greater discernment and compassion, and enhanced capacity to recognize and disidentify from one's conditioned concept of the self." (Shapiro & Carlson, 2009, p. 8). Theoretically, mindfulness meditation increases mindfulness and, in turn, mindfulness improves one's relationships with the self and with others (Kristeller & Johnson, 2005).

When applied to the context of psychotherapy, the therapist's capacity for an open relationship with oneself, also known as intrapersonal attunement, is a crucial precursor to creating an attuned relationship with the client (Bruce et al., 2010; Siegel, 2007a). Bruce et al. (2010) theorized that any experiences that the therapist is unable to hold in awareness (i.e., those experiences they push out of consciousness and/or those that threaten to overwhelm them) will affect the psychotherapist's ability to hold similar experiences in clients and thereby result in countertransference reactions. When the therapist is instead able to stay present and attuned, the client's self-isolation and fear can be processed and laid to rest. Siegel (2007a) posited that mindfulness is the heart of therapeutic change.

Empirical exploration of the influence of therapist mindfulness on the therapeutic relationship, however, is in its infancy (Davis & Hayes, 2011). In the only known study examining therapist mindfulness, the working alliance, and treatment outcome, Ryan, Safran, Doran, and Muran (2012) found that therapists' self-reported mindfulness was positively and significantly correlated with client ratings of the working alliance. Moreover, therapist mindfulness was associated with improvements in clients' overall interpersonal functioning. Although promising, these findings have yet to be replicated with respect to the working alliance and extended to the real relationship.

Countertransference management, a critical aspect of effective therapeutic relating (Gelso, 2014), also has not been studied extensively in relation to mindfulness. Research that has examined the effects of mindfulness-based stress reduction (MBSR) and long-term meditation has demonstrated that mindfulness practices may help to foster the therapist qualities theorized to constitute countertransference management (Keane, 2014; Schure, Christopher & Christopher, 2008; Shapiro, Brown, & Biegel, 2007).

Countertransference Management and Mindfulness Among Therapists in Training

Only one known study has directly examined the relationships among mindfulness, meditation, and countertransference management in a sample of therapists in training (Fatter and Hayes, 2013). In their study, Fatter and Hayes (2013) demonstrated that dispositional mindfulness, trainee reported meditation experience, and self-differentiation predicted supervisor ratings of countertransference management abilities as hypothesized; however, years of meditation experience was the only significant and unique predictor of countertransference management ability. The current study sought to replicate and extend these findings by examining therapist mindfulness within the context of the tripartite model of the therapeutic relationship.

Statement of Purpose and Hypotheses

Because mindfulness-based skills can be taught and learned, gaining a more sophisticated understanding of the role of therapist mindfulness relative to countertransference management and the therapeutic relationship has the potential to expand our understanding of psychotherapy and further advance contemporary psychotherapy training models. The theoretical links among therapist mindfulness, countertransference management, and the therapeutic relationship have not yet been thoroughly examined. The purpose of the current study was to explore the role of therapist mindfulness within the context of Gelso and Carter's (1985; 1994) tripartite model of the therapeutic relationship. The study investigated the relationships among therapist mindfulness, countertransference management, and two fundamental aspects of the therapeutic relationship (the real relationship and the working alliance) in a sample of therapists in training.

Based upon mindfulness theory and preliminary empirical findings highlighting the interpersonal benefits of mindfulness and its role in promoting effective therapeutic relating

(Bruce et al., 2010; Ryan et al., 2007; Siegel, 2007a), it was hypothesized that therapist mindfulness will positively predict ratings of the real relationship and working alliance. In keeping with Gelso & Carter's (1985, 1994) tripartite model of the therapeutic relationship, it was further hypothesized that countertransference management ability will partially mediate the positive relationship between therapist mindfulness and ratings of the real relationship and working alliance. As therapists in training often struggle to identify and manage countertransference (Hill et al., 2007; Howard et al., 2006), data was collected from trainee-supervisor dyads. Ratings of trainee countertransference management were provided by trainees' current clinical supervisors; ratings of therapist mindfulness, the real relationship, and the working alliance were provided by therapists in training. As exposure to mindfulness-based skills training has been shown to impact response patterns to self-report measures of dispositional mindfulness and thus may impact the strength and direction of the hypothesized associations (Baer et al., 2008; Christopher et al., 2009), additional information regarding meditation experience was also collected from therapists in training and examined as a potential moderator. Because meditation experience enhances awareness and decreases reactivity, it was hypothesized that meditation experience will strengthen the associations between therapist mindfulness and countertransference management.

Based upon the aforementioned theoretical (e.g., Bruce et al., 2010; Gelso & Carter, 1985, 1994; Siegel, 2007a) and empirical (e.g., Baer et al., 2008; Christopher et al., 2009; Fatter & Hayes, 2013; Ryan et al., 2012) findings, the following hypotheses were proposed:

- **Hypothesis 1:** The real relationship and working alliance will be significantly and positively related.

- **Hypothesis 2:** Therapist mindfulness and supervisor rating of therapist countertransference management will relate significantly and positively to therapist rating of the real relationship.
- **Hypothesis 3:** Therapist mindfulness and supervisor rating of therapist countertransference management will relate significantly and positively to therapist rating of working alliance.
- **Hypothesis 4:** Therapists' self-reported mindfulness will positively relate to supervisor ratings of therapist countertransference management.
- **Hypothesis 5:** Meditation experience will moderate the relationship between therapist self-reported mindfulness and supervisor rating of therapist countertransference management, such that more extensive meditation experience will strengthen the relationship between therapist mindfulness and supervisor-rated countertransference management.
- **Hypothesis 6:** Supervisor rating of therapist countertransference management will partially mediate the relationship between therapist mindfulness and therapist rating of the real relationship.
- **Hypothesis 7:** Supervisor rating of therapist countertransference management will partially mediate the relationship between therapist mindfulness and therapist rating of the working alliance.
- **Hypotheses 8a:** Results will support evidence of moderated mediation as depicted in Figure 1. Specifically, supervisor rating of therapist countertransference management will mediate the positive relationship between therapist mindfulness and the real relationship and therapist meditation experience will moderate this mediated relationship,

such that more therapist meditation experience will strengthen the positive relationship between therapist mindfulness and the real relationship.

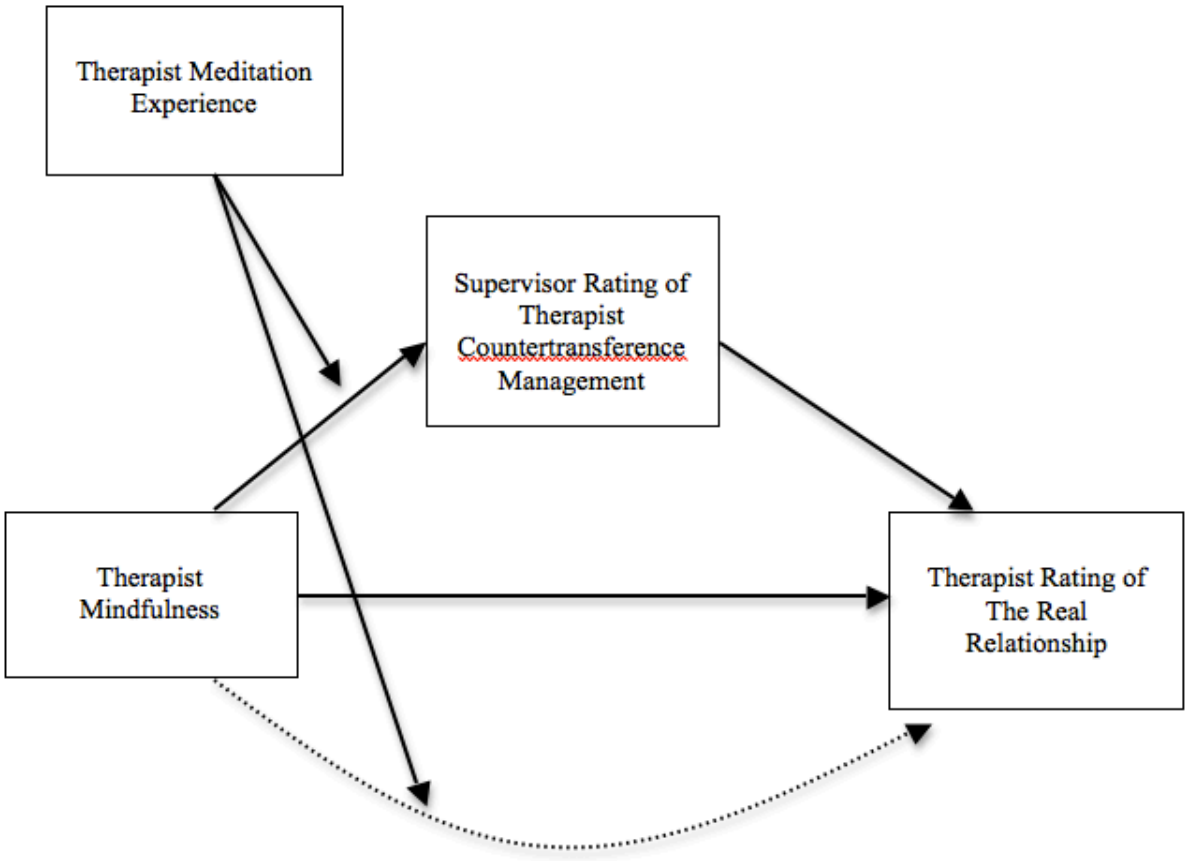

Figure 1.1

- **Hypothesis 8b:** Results will support evidence of moderated mediation as depicted in Figure 2. Specifically, supervisor rating of therapist countertransference management will mediate the positive relationship between therapist mindfulness and the working alliance and therapist meditation experience will moderate this mediated relationship, such that more therapist meditation experience will strengthen the positive relationship between therapist mindfulness and the working alliance.

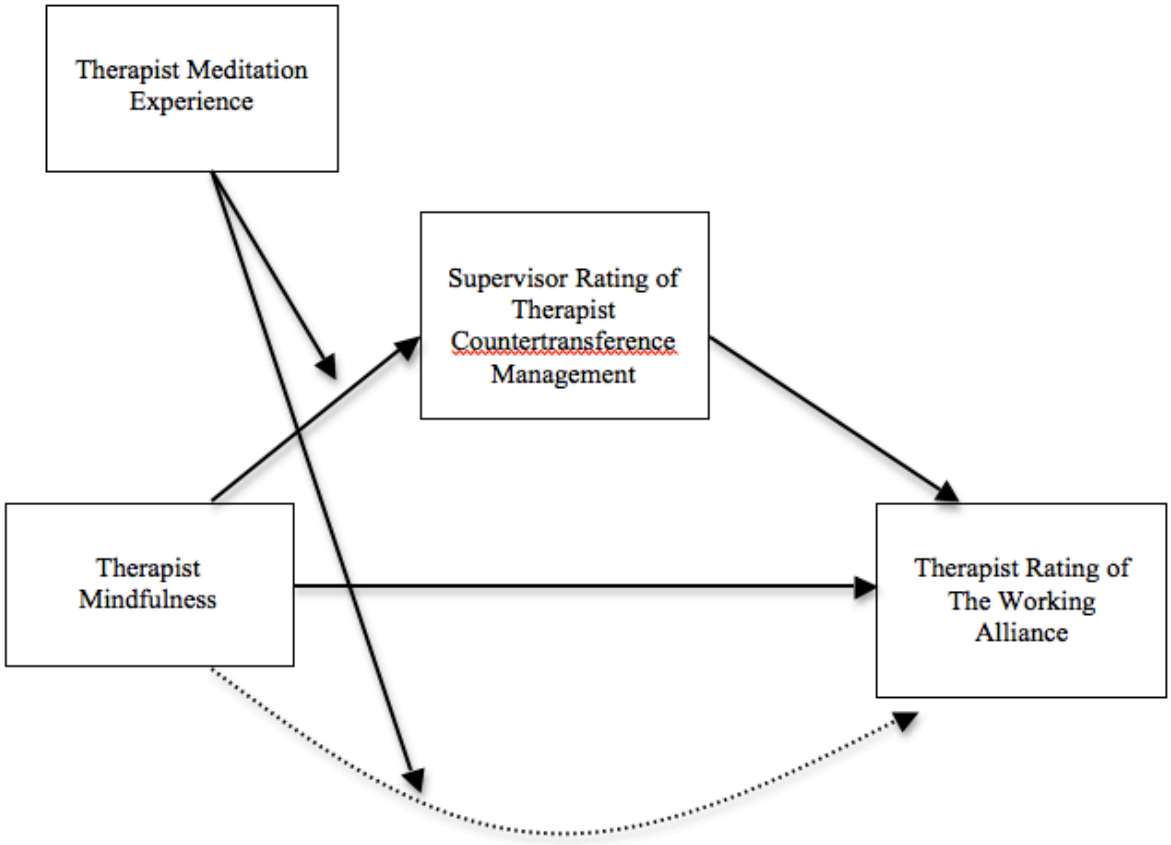
Therapist Meditation Experience
Supervisor Rating of Therapist Countertransference Management
Therapist Mindfulness
Therapist Rating of The Working Alliance

Figure 1.2

Chapter II: Review of the Literature

Research investigating the effectiveness of psychotherapy has largely been dominated by efforts to establish the superiority of one theoretical approach or treatment over another (Elkins, 2012). Beginning in the late 1970s, pressure from managed care companies and the health insurance industry to demonstrate the scientific validity of psychotherapy treatments served to further intensify these efforts. In response, Division 12, Society of Clinical Psychology, of the American Psychological Association (APA), formed a task force to identify what would eventually be called "empirically supported treatments." Despite available research indicating that all bona fide therapies are robustly effective, millions of research dollars were directed toward randomized control trials (RCTs) comparing the efficacy of various theoretical approaches (e.g., Elkins, 2007; Wampold, 2001). As a result, psychotherapy research, training, and practice began to become based upon the assumption that specific modalities and techniques are the primary mechanisms of change.

Countering this assumption, a number of scholars and researchers (Frank & Frank, 1991; Wampold & Imel, 2015) have suggested that factors common to all modes of therapy are the primary determinants of psychotherapy's effectiveness. Originally proposed by Jerome Frank in 1946, factors common to all therapies include: an emotionally charged confiding relationship with a helping person; a healing setting that involves the client's expectations that the professional helper will assist him or her; a rationale, conceptual scheme, or myth that provides a plausible, although not necessarily true, explanation of the client's symptoms and how the client can overcome their demoralization; and a ritual or procedure that requires the active participation of both client and therapist and is based on the rationale underlying the therapy (Frank & Frank, 1991). It was not until the advent of meta-analytic methods that a common factors approach

began to be rigorously empirically examined against the assumptions of the specific ingredients perspective (Wampold, 2001; Wampold & Imel, 2015). In landmark studies, Wampold and colleagues (e.g., Ahn & Wampold, 2001; Benish, Imel, & Wampold, 2008; Messer & Wampold, 2002; Wampold, 2001; Wampold et al., 1997; Waehler, Kalodner, Wampold, & Lichtenberg, 2000) reviewed decades of research and conducted meta-analyses of hundreds of studies to identify the determinants of psychotherapy's effectiveness. The results were conclusive: there were no differences in outcomes across treatments intended to be therapeutic (Benish et al., 2007; Imel, Wampold, Miller, & Fleming, 2008; Miller, Wampold, & Varhely, 2008).

Subsequent studies found that therapist effects and the relationship between client and therapist were more powerful predictors of treatment outcome than any specific treatment provided, accounting for up 69% and 54% of the variance in treatment outcomes, respectively (Beutler et al., 2003; Duncan, 2010; Wampold & Brown, 2005; Wampold & Imel, 2015). Likewise, there is also evidence to suggest that therapists vary in their influence on the therapeutic alliance (Del Re, Horvath, Fluckiger, Symonds, & Wampold, 2012). In light of this mounting empirical evidence, there have been increased calls for clinical scientists to set aside theoretical allegiances and work together to adopt a common focus in psychotherapy research. Namely, a focus on intra- and interpersonal factors – or what Elkins (2012) terms the "humanistic" elements of psychotherapy. Elkins (2012) argued that "psychotherapy can best be understood not as a set of medical-like techniques and procedures but, rather, as a human relationship that is an expression of an evolutionarily derived predisposition to give and receive care in situations of vulnerability" (p. 452).

In the last decade, there have been significant advances in our understanding of the humanistic factors that impact therapeutic outcomes. Yet, in reviewing these findings, three

methodological considerations are important to note: issues of definition and operationalization, how data was collected, and the level of analysis selected. Careful review shows that the answer to a given research question may vary depending upon the measure used to quantify intra- and interpersonal factors, client versus therapist report, and whether effects are examined at the client/dyad level (i.e., within-therapist effects) or at the therapist level (i.e., between-therapist effects). Moreover, therapist effects, defined as "the effect of a given therapist on patient outcomes as compared to another therapist" (Baldwin & Imel, 2013, p. 260) are frequently confounded with effects at the client or dyad level, making many research results difficult to interpret (Curran & Bauer, 2011). As such, when reviewing the literature below, important details about the definition and operationalization of constructs, how data was collected, and the level of analysis examined were highlighted.

The Therapeutic Relationship

Despite competition among various schools of psychotherapy, virtually all agree that the relationship between client and therapist has a significant impact upon the process and outcome of treatment (Lambert & Barley, 2002; Gelso, 2011; Norcross, 2002, 2011). Although empirical research seems to support this generalization, very little effort has been made to clearly define the therapeutic relationship. Gelso and Carter (1985) argued that existing definitions of the therapeutic relationship are largely inadequate as they either conflate the therapeutic relationship with therapist offered conditions of congruence, unconditional positive regard, and empathy or falsely equate the relationship with the working alliance. Noting the complex and dyadic nature of the therapeutic relationship, Gelso and Carter (1985) instead defined the therapeutic relationship as "the feelings and attitudes that the therapist and client have toward one another and the manner in which they are expressed" (p. 159). In response to criticisms of this definition

as too broad and overly inclusive, Gelso (2011) maintained that any sound definition must incorporate the expression of feelings and attitudes as without expression there can be no relationship. Gelso (2011) further asserted that it is equally important to understand that the expression of feelings and attitudes take on many forms, including subtle variations in facial expressions, eye movements, and other nonverbal behaviors.

Gelso and Carter's Tripartite Model

One strategy to better understand the therapeutic relationship is to divide the overall therapeutic relationship into its component parts (Gelso & Carter, 1985, 1994; Gelso & Hayes, 1998). Building upon the work of Ralph Greenson (1965, 1967), Gelso and Carter (1985, 1994) divided the overall relationship into three components: the real relationship, the working alliance, and the transference-countertransference configuration. Originally rooted in psychoanalytic theory, these three components are viewed as transtheoretical relational processes within the tripartite model. Each element of the therapeutic relationship is present from the first moment of contact between therapist and client and sometimes even before contact in the form of the client and therapist fantasies about one another. The components of the therapeutic relationship are both interrelated and separate, and each influences the others as well as the process and outcome of treatment. The extent to which one or the other is salient at a given time in the therapeutic interaction depends upon several factors, including: the particular point in treatment, treatment duration, the therapist's theoretical orientation, the personality dynamics of the client, the presenting problem, and the quality of the therapeutic relationship (Gelso, 2011). In the following sections, each component of the tripartite model, the theorized relationships among them, and the existing empirical research examining the model are reviewed.

The Real Relationship. The concept of the real relationship itself dates back to the birth of the talking cure. Indeed, the real relationship was frequently referenced in the writings of several early psychoanalysts, including Freud himself (Gelso, 2011). As the first to describe and explore the concept of the real relationship in a comprehensive and far-reaching way, Ralph Greenson (1965, 1967) proposed that there were two defining features of the real relationship: realistic perception/reaction and genuineness. The real relationship included the authentic being of the therapist, or their personality and behavior. Greenson (1965, 1967) contended that this authenticity of both being and behaving with the client was a key part of psychotherapy.

Gelso and colleagues (Gelso, 2011, 2014; Gelso et al., 2005, Gelso & Samstag, 2008) further refined Greenson's (1965, 1967) formulation of the real relationship, defining it as "the personal relationship existing between two or more persons as reflected in the degree to which each is genuine with the other and perceives the other in ways that befit the other" (Gelso, 2014, p. 119). Genuineness is viewed as being authentic or who one truly is as opposed to being phony or fake. Realism is conceived of as experiencing and perceiving the other in ways that befit the other rather than in ways that fit what the perceiver wishes for, needs, or fears. In articulating the importance of both genuineness and realism, Gelso (2011) asserted that,

> It is hard to imagine a good personal relationship, one considered real by the participants, in which these two ingredients do not exist or exist only to a small extent. The inability or unwillingness to be oneself, but instead being phony, obviously does not make for a good personal or real relationship. Indeed, it is hard to feel the other is real if he is not sharing himself in ways that seem authentic. In this sense phony and real are mutually exclusive. As for realism, a person is unlikely to feel that she is involved in anything like a real relationship if she does not feel the other was grasping her in a way that fit her but

> instead seemed to fit others, perhaps the perceiver, more than her. The relationship would not feel real or realistic, and would yield comments such as "Where are you coming from?" and "I just don't think you have a clue as to who I am" (p. 13).

The real relationship is, thus, viewed as the foundation of the therapeutic relationship (Gelso, 2014). Genuineness and realism are theorized as occurring in each and every therapeutic encounter to varying degree and valence. Accordingly, Gelso and Carter's (1985) conceptualization of the real relationship has been further refined to take into account both how much genuineness and realism exist (magnitude) and the extent to which the realism and genuineness are positive versus negative (valence; Gelso, 2014). Regarding valence, it is important to note that one can be genuine and realistically perceive the other negatively. For example, a client can perceive a therapist realistically, be genuine, and not like the therapist. The combination of genuineness and realism with magnitude and valence yields an index of the strength of the real relationship, with greater magnitude and more positivity in valence generally indicating a stronger real relationship. It is theorized that the stronger the real relationship, the more effective the therapy (Gelso, 2014).

The Working Alliance. Whereas the real relationship serves as the foundation of the overall therapeutic relationship, the working alliance functions as a catalyst for therapeutic change (Gelso, 2014). Greenson (1965, 1967) observed that the real relationship is a part of all human encounters whereas the working alliance is solely an artifact of psychotherapy. Further building on Greenson's (1965, 1967) seminal work, Gelso and Carter (1994) defined the working alliance as "the alignment or joining together of the reasonable self or ego of the client and the therapist's analyzing or therapizing side for the purpose of the work" (p. 297). This definition draws upon Sterba's (1934) concept of the split ego. The ego is seen as having both

reasonable/observing capacities and experiencing capacities. The working alliance stems from the capacity to reasonably observe oneself and one's experiences. In the face of emotional obstacles and resistance, the joining together of the client and therapist reasonable sides allows the work of psychotherapy to proceed (Gelso, 2011). This joining is stimulated by the client's wish to heal and by their willingness to cooperate as well as by the therapist's aim of helping the client in their quest.

Keeping with Bordin's (1979, 1994) conceptualization, the working alliance is influenced by client and therapist agreement on the following: 1) the goals of the work – that they are both worthwhile and attainable; 2) the tasks that are to be performed in order to attain those goals; and 3) the working bond between the client and therapist (Gelso & Hayes, 1998). The goals, tasks, and bond influence the working alliance and in turn, the working alliance shapes the goals, tasks, and bond. Although the goals, tasks, and bond may vary across theories they are nonetheless central to all effective therapies. The fundamental reason for the existence of the working alliance is to further the work of therapy (Gelso & Hayes, 1998). Like the real relationship, a strong working alliance will generally yield better therapeutic outcomes.

The Transference Configuration. The concept of transference is often regarded as Sigmund Freud's greatest contribution to psychological treatment (Gelso, 2014). Since Freud's first articulation of transference, the conceptions and definitions of transference have changed substantially, corresponding with shifts in relational and intersubjective theories. Classical definitions restrict transference to reactions to the analyst originating in the client's original Oedipus complex. More totalistic definitions include all of the client's reactions to the therapist. Within the tripartite model, transference is defined as "the client's experience and perceptions of the therapist that are shaped by the client's own psychological structures and past, involving

carryover from and displacement onto the therapist of feelings, attitudes, and behaviors belonging rightfully to and in earlier significant relationships" (Gelso, 2014, p. 121). Transference is regarded as a universal aspect of all therapies. However, the extent and salience of transference naturally depends upon the theoretical inclinations of the therapist, the conditions established by the therapist, and the client's personality and presenting problems.

Much like transference, the concept of countertransference has undergone considerable debate and revision. Classical definitions narrowly defined countertransference as the therapist's reaction to client transference. Still other totalistic definitions include all of the therapist's reactions to clients. Gelso and Hayes (2007) asserted that these overly narrow and broad conceptualizations are both clinically and empirically untenable and instead put forth an integrative definition of countertransference as "the therapist's internal or external reactions that are shaped by the therapist's past or present emotional conflicts and vulnerabilities" (p. 25). According to this definition, countertransference may be stimulated by the client or by the therapeutic frame. Either way, it is rooted in the therapist's emotional conflicts or vulnerabilities. Although countertransference was initially viewed as something to be eliminated, there is now general agreement that countertransference is inevitable. Within the tripartite model, the effect of countertransference depends on how the therapist is able to understand and manage their internal reactions to the client (Gelso & Hayes, 2007). If countertransference is poorly understood and managed, it will tend to spill into the session and threaten the work of therapy. Countertransference can, however, be used by the therapist to aid their understanding of the client and the client's impact on others if it is effectively managed (Gelso, 2014).

Theorized Connections Across Variables. In theory, the real relationship, working alliance, and transference-countertransference configuration are in constant interaction and synergy. One key way in which the components operate interactively is through the influence that each has on the others. Within the tripartite model, the working alliance is theorized to emerge from the real relationship and together influence the extent to which the client is able to express and gain an understanding of difficult and painful transference feelings. Such transferences affect the working alliance and real relationship and, in turn, affect therapist countertransference. How therapists deal with countertransference has major implications for transference, the working alliance, real relationship, and treatment in general.

Empirical Findings and Limitations of Prior Research

The Real Relationship. Due to differing theoretical views and thorny political disagreements on the nature of reality and who has the power to define what is "real," the real relationship between therapist and client has received relatively little empirical attention. Research on the real relationship has been based primarily upon a philosophy of constructive realism (Gelso, 2011). Initially described by the cognitive psychologist Ulric Neisser (1967), constructive realism captures the idea that there is a reality of the client (and the therapist) but that all the therapist can access is the reality that the client and therapist co-construct as the therapist seeks to deeply understand the client. Accordingly, research on the real relationship has been examined from both client and therapist perspectives. Empirical findings point to meaningful associations between the real relationship and session quality (Eugster & Wampold, 1996; Gelso et al., 2005) and between the real relationship and treatment outcomes across diverse theoretical orientations (Fuertes et al., 2007; Gelso et al., 2012; Lo Coco, Gullo, Prestano, & Gelso, 2011; Marmarosh et al., 2009; Owen, Tao, Leach, & Rodolfa, 2011). For

example, in a study examining within-therapist effects among a sample of 59 client-therapist dyads, Fuertes et al. (2007) found that both client and therapist ratings of the real relationship were positively associated with ratings of client progress as measured by the Counseling Outcome Measure (COM; Gelso & Johnson, 1983). In another study conducted by Marmarosh et al. (2009), hierarchical linear modeling (HLM) of client/dyad effects across therapists showed that therapist ratings of the real relationship were predictive of treatment outcome as measured by client reported reductions in symptom severity. Client perceptions of the real relationship did not account for a significant amount of variance in post-treatment symptoms (Marmarosh et al., 2009).

Recently, researchers have begun to examine the mutual influence and interdependence in therapist and client ratings of the real relationship using an actor-partner interdependence model (APIM) to simultaneously analyze the relationships between therapist and client ratings of the real relationship, session quality, and treatment outcomes (Gelso et al., 2012; Kivlighan, Jr. et al., 2015; Kivlighan Jr., et al., 2016). Of particular relevance to the proposed study, Kivlighan, Jr. et al. (2015) used APIM to decompose the relationship between treatment progress (as rated by both the client and therapist) and the real relationship (also rated by both the client and therapist) into within-therapist and between-therapist effects. Analysis revealed that clients whose therapists provided higher average levels of client-perceived real relationship across the clients treated by a given therapist had better progress ratings from themselves and their therapists. Within each therapist's caseload, differences between clients in client or therapist rated real relationship were unrelated to either client or therapist rated outcome. Clients whose therapists provided higher average levels of therapist perceived real relationship, across the clients treated by the therapist, had worse progress ratings from the therapists. Based upon these

findings, Kivlighan, Jr. et al. (2015) concluded that between-therapist differences are particularly important in establishing the real relationship and in turn, facilitating therapeutic outcomes. To date, however, there have been no published studies investigating the impact of particular therapist factors on the real relationship and very little is known about how therapists can work to strengthen the real relationship (Gelso, 2014).

The Working Alliance. In contrast to the real relationship, the working alliance is one of the most frequently investigated topics in psychotherapy research. Numerous findings suggest that the strength of the working alliance is a significant predictor of psychotherapy outcomes across treatment conditions (Horvath & Bedi, 2002; Lambert & Barley, 2002). The results of multiple meta-analytic studies suggest that the strength of the working alliance demonstrates a modest but consistent impact on psychotherapy outcomes, with effect sizes ranging from .22 to .27 (Horvath, Del Re, Flukiger, & Symonds, 2011; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). For example, a meta-analysis conducted by Tryon and Winograd (2011) found that client and therapist agreement on the goals and tasks of therapy (r = .34) and engagement in an active cooperative relationship (r = .33) enhanced treatment outcomes, as measured by changes in psychological symptoms and general functioning. Scholars have concluded that the working alliance is an essential ingredient in producing therapeutic change (Doran, 2016). Accordingly, it has been recommended that therapists focus on establishing strong and positive working relationships with their clients from the outset of treatment (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Doran, 2016; Horvath & Bedi, 2002). However, the exact intra- and inter- personal competencies required to facilitate such therapeutic relating and how therapists are to acquire these competencies have yet to be empirically established.

The Transference Configuration.

Transference. In further support of the tripartite model, research seems to suggest that transference exists in both analytic and nonanalytic therapies and contributes to treatment outcomes across theoretical orientations (Gelso & Bhatia, 2012; Gelso, 2014). Gelso and Bhatia (2012) reviewed 16 qualitative and quantitative studies that examined transference in either non-analytic therapies or in samples of therapists with diverse theoretical orientations. Based upon their review, they reached the following three conclusions: 1) transference occurs in non-analytic therapies with a similar frequency as it does in analytic therapies; 2) the content of transference is essentially the same in both non-analytic and analytic therapies; and 3) transference is likely to show itself whether or not the therapist attends to it (Gelso & Bhatia, 2012).

These findings are consistent with an accumulation of experimental findings in social psychology that confirm the existence of transference, such that "prior relationships can and do play out in present ones" (Andersen & Pryzbylinski, 2012, p. 381). In a series of experiments conducted with non-clinical samples, Andersen and colleagues (Andersen & Baum, 1994; Andersen, Reznick, & Manzella, 1996; Berk & Andersen, 2000; Berk & Andersen, 2008; Hinkley & Andersen, 1996) first primed positive or negative transference by asking participants to identify and describe two significant others with whom their goals for affection had or had not been satisfied. Participants were then recruited to participate in a seemingly unrelated study two weeks later where they were provided with information about and then instructed to solicit liking from a confederate who resembled their significant other. Participants in the negative transference condition reported increased feelings of distaste and intolerance, expectations of rejection, and behavioral avoidance; participants in the positive transference condition reported increased feelings of liking and tolerance, expectations of acceptance, and approach behaviors.

In their review of these findings, Andersen and Pryzbylinski (2012) theorized that negative transference may weaken the therapeutic relationship while positive transference may enhance the therapeutic relationship thereby impacting the process and outcome of therapy in important and meaningful ways.

Preliminary research with clinical samples suggests that the valence of transference, whether negative or positive, is related to session and treatment outcome (Gelso, 2014). In the only study to use independent, external raters of transference and the session quality of videotaped therapy sessions across 132 sessions in a sample of 44 client-therapist dyads (comprised of 44 clients nested within 4 therapists), Markin et al. (2013) reported evidence of within-therapist effects such that clients' negative transference (defined as the client's projection of negative attitudes on to the therapist, based on needs tied to past conflictual relationships) predicted rougher therapy sessions as measured by the smoothness subscale of the Session Evaluation Questionnaire (SEQ; Stiles & Snow, 1984). In contrast, external ratings of positive transference (defined as the client's projection of positive attitudes onto the therapist, based on needs tied to past conflictual relationships) positively predicted deep sessions as measured by the depth subscale of the SEQ (Markin et al., 2013). HLM analyses did not reveal any significant between-therapist effects.

With respect to treatment outcomes, Gelso, Kivlighan, Wine, Jones, & Friedman (1997) found that therapist ratings of negative transference (as measured by the Transference and Insight questions developed by Graff and Luborsky, 1977) in the final quarter of brief therapy differentiated more from less successful cases as rated by both therapists and clients. The less successful cases exhibited a dramatic increase in negative transference whereas the more successful cases showed a drop in transference during the final quarter of treatment. Although

promising, confounding at the client and therapist level of analysis limits the interpretability of these findings. Subsequent research from Marmarosh et al. (2009) found that therapist-rated negative transference was positively correlated with treatment outcome as measured by client reported reductions in symptom severity at the client/dyad level of analysis.

Taken together, it can tentatively be concluded that client transference exerts modest main effects on session and treatment outcome (Gelso, 2014). However, these main effects appear to be modified by interaction effects (Gelso, 2014; Markin et al., 2013). For example, the impact of negative transference on session and treatment outcome may depend on the client's level of emotional insight (Gelso, Hill, & Kivlighan, 1991; Gelso & Hayes, 1998). In an early study investigating the interactive effects of client transference and insight on session quality, 38 therapists were asked to audio record a client session and then rate the client's level of transference and insight as well as session quality within 24 hours of the recorded session (Gelso et al. 1991). Results at the client/dyad level (i.e., within-therapist effects) indicated that high negative transference was positively associated with session quality when the client was rated as highly emotionally insightful by the therapist (Gelso et al. 1991). However, when the client was rated by the therapist as having low emotional insight, high negative transference was negatively associated with session quality (Gelso et al,1991).

The effects of transference on treatment outcome also may partly depend upon how the transference is handled by the therapist. In a randomized clinical trial examining the long-term effects of transference interpretation in dynamic therapy, Johansson et al. (2010) found that clients benefitted more from therapy with transference interpretation than from therapy with no transference interpretation, an effect that was mediated by an increase in the level of insight during treatment. This finding offers initial confirmation of Gelso and Carter's (1985, 1994)

countertransference interaction hypothesis, or the conceptualization of client transference and therapist countertransference as interactive and mutually related to treatment outcomes.

Countertransference. Consistent with the tripartite model, research indicates that countertransference is a commonly occurring phenomenon (Hayes et al., 1998; Pope & Tabachnick, 1993). For example, a qualitative study of eight expert therapists reported that therapists identified countertransference in 80% of their 127 sessions of brief therapy even when the more conservative and integrative definition of countertransference (i.e., the therapist's internal or external reactions that are shaped by the therapist's past or present emotional conflicts and vulnerabilities) was used (Hayes et al., 1998). A meta-analysis of 10 quantitative studies demonstrated a modest negative relationship between self-reported countertransference-based feelings and behaviors and treatment outcome, but the relationship was stronger when outcome measures are more distal (e.g., ratings or measures of outcome) than proximal (e.g., experiencing level in sessions; Hayes et al., 2011).

Interrelationships Among Variables: The Real Relationship and Working Alliance. A growing body of literature supports the factor structure and theorized interrelationships among the real relationship, working alliance, and transference-countertransference configuration (Gelso, 2014). According to the tripartite model, the working alliance emerges from the real relationship between client and therapist. Given the conceptual overlap between these two constructs, covariation would be expected between measures of the real relationship and working alliance, and prior research has demonstrated that they positively and uniquely predict therapeutic outcomes (Gelso, 2014; Gelso & Carter, 1994; Gelso & Hayes, 1998). Empirical findings show moderate correlations between therapists' ratings of the real relationship and working alliance (ranging from .50 to .69), such that higher ratings of both constructs are unique

predictors of session and treatment outcome (Bhatia & Gelso, 2017; Fuertes et al., 2007; Gelso et al., 2005; Lo Coco et al., 2011; Marmarosh et al., 2009).

Client ratings of the real relationship and working alliance are often highly correlated (ranging from .70 to .80), suggesting that clients may view the two constructs as one in the same (Fuertes et al., 2007; Kelley, Gelso, Fuertes, Marmarosh, & Lanier, 2010; Lo Coco et al., 2011; Marmarosh et al., 2009; Owen et al., 2011). Despite the high degree of overlap in client ratings of the real relationship and working alliance, research (e.g., Fuertes et al., 2007; Marmarosh et al., 2009; Lo Coco et al., 2011) has demonstrated that client ratings of the real relationship predict treatment progress and outcome above and beyond the variance accounted for by the working alliance; a finding that provides empirical support for Gelso and Carter's (1985, 1994) conceptualization of the real relationship and working alliance as two distinct, yet related aspects of the therapeutic relationship. Taking this a step further, Gullo, Lo Coco, and Gelso (2012) examined the relationship of these two variables over the course of treatment. They found that correlations of therapist and client ratings of the real relationship and working alliance grew stronger as therapy progressed, suggesting that as the therapeutic relationship deepens, the real relationship and working alliance may blend together.

Summary and Implications

Existing theory and empirical research on the tripartite model of the therapeutic relationship point to the mutual influence of the real relationship, working alliance, and the transference-countertransference configuration on psychotherapy outcomes (Gelso, 2014). Recent findings have also highlighted the influence of therapist factors on various aspects of the therapeutic relationship (Kivlighan, Jr. et al., 2015). It has been theorized that the ability to manage and use countertransference therapeutically may be a particularly important therapist

factor contributing to the success of psychotherapy outcomes. Yet, to date, there have been no published studies investigating the impact of countertransference management on the real relationship or the working alliance between client and therapist. In the current study, we hypothesized that therapists' countertransference management abilities would positively predict ratings of the real relationship and working alliance.

Countertransference Management

The tripartite model of the therapeutic relationship posits that the ability to manage countertransference has major implications for the real relationship, working alliance, and in turn, treatment outcomes (Gelso, 2011, 2014). Indeed, countertransference reactions can be an obstacle to realistic perception and genuine expressions of empathic understanding (Gelso, 2011). Yet, as long as the therapist seeks to understand and use these reactions therapeutically, countertransference reactions may deepen the therapeutic relationship and benefit the work of therapy (Gelso & Hayes, 2007). Accordingly, therapists must cultivate a set of skills and qualities that will allow them to identify and harness countertransference reactions to clients, to be vigilant to possibly acting on these reactions in injurious ways, and to derive clinically meaningful insights from these reactions (Gelso & Hayes, 2007).

Five-Factor Model of Countertransference Management

Drawing from existing empirical research and extensive clinical writings on countertransference, Van Wagoner et al. (1991) theorized that the management of countertransference consists of five interrelated therapist factors: self-insight, conceptualizing ability, empathy, self-integration, and anxiety management. Theoretically, these five factors work in concert to enhance the therapist's ability to accurately perceive and understand their clients (Gelso, 2011).

Self-insight. Self-insight is defined as the therapist's awareness and understanding of their thoughts, feelings, behaviors, sensations, motives, and histories (Hayes et al., 1991; Van Wagoner et al., 1991). Self-insight is viewed as a fundamental aspect of countertransference management. As the therapist inevitably perceives clients through their own inner world, an understanding of the clients is limited by the extent to which a therapist understands themself. If therapists do not understand this inner world, their understanding of the client's inner world is bound to be less accurate (Gelso, 2011). Further, a lack of self-insight may leave therapists vulnerable to projecting their own unresolved conflicts onto the client and acting out behavioral manifestations of countertransference, including: ignoring, blaming, rejecting, or colluding with clients (Gelso, 2011; Gelso & Hayes, 2007).

Research generally suggests that therapists who are aware of their countertranference-based feelings are in a better position to do something about them before they are manifested behaviorally (Hayes, Nelson, & Fauth, 2015; Peabody & Gelso, 1982; Robbins and Jolkovski, 1987). Qualitative interviews with 18 therapists using grounded theory methods found that therapists who were not aware of their countertransference at the time to adequately manage it tended to view their countertransference as directly related to negative therapeutic outcomes. Those who reflected, either by themselves, with their clients, or with colleagues tended to believe that they had more successfully managed their countertransference and tended to see poor outcomes as unrelated to their countertransference and more related to salient client factors when negative outcomes occurred. In a sample of 17 client-therapist dyads (examining client/dyad or within-therapist effects) Fauth and Williams (2005) similarly found that trainee-rated awareness of their thoughts, feelings, behaviors, and physiological responses in session was positively related to client ratings of the working alliance.

Conceptualizing Ability. Conceptualizing ability refers to the therapist's use of theory to understand the client and the dynamics of the therapeutic relationship (Hayes et al., 1991; Van Wagoner et al., 1991). Conceptualizing skills are thought to prevent the acting out of countertransference reactions by providing a framework for understanding them and knowing how to manage them effectively. However, empirical findings indicate that conceptualizing ability, in itself, does not prevent countertransference (Hofsess & Tracey, 2010; Latts & Gelso, 1995; Robbins & Jolkovski, 1987). Instead, experimental studies on countertransference management have pointed to the interactive nature of self-insight and conceptualizing ability (Gelso et al., 1995; Latts & Gelso, 1995; Robbins & Jolkovski, 1987). In these studies therapists in training were presented with standardized case material and a pre-recorded client role-play and asked to imagine that they had been meeting with the client for five sessions. Trainees' responses to the client at specific stopping points were recorded and then coded by a team of trained raters for approach (i.e., responses that served to elicit further expressions of feelings and attitudes from the client) and avoidance (i.e., responses that served to inhibit, discourage, or divert the client from further expression). Former supervisors provided ratings of the trainees' conceptual abilities and self-insight. Results showed that the use of theory to conceptualize clients, in the absence of self-insight, predicted avoidance (Gelso et al., 1995; Latts & Gelso, 1995). However, when combined with even moderate levels of self-insight, theoretical conceptualizations predicted approach (Gelso et al., 1995; Latts & Gelso, 1995).

Empathy. Therapist empathy is generally understood to be a critical aspect of successful therapy (Gelso, 2011). Empathy is defined as the ability to grasp intellectually and, to a degree, feel what the client feels within the client's frame of reference (Hayes et al., 1991; Van Wagoner et al., 1991). In this way, empathy is a key part of countertransference management as well.

According to Gelso (2011), “The therapist’s ability to climb into and emotionally as well as cognitively grasp the client’s underlying feelings, anxieties, wishes, and fears is part and parcel of perceiving the client in ways that befit the client” (p. 52). Gelso (2011) argued that although this partial identification is vitally important, it is equally important that the identification not be too great. Enough distance is needed to ensure that the therapist and client do not become fused and the therapist is able to offer the client a perspective that is different from their own. Countertransference, therefore, occurs when therapists are unable to extricate themselves from their identification with the client.

Research examining the role of empathy and countertransference management indicates that empathy may help to prevent countertransference behavior (Gelso & Hayes, 2007; Peabody & Gelso, 1982). In a two-part experimental study, Peabody and Gelso (1982) found that therapists’ self-reported ability to empathize positively predicted their awareness of countertransference-based feelings in response to audio-recordings of three clients as measured by a nine-item self-report countertransference survey (Peabody & Gelso, 1982). Therapists’ self-reported awareness of countertransference was then inversely related to countertransference behavior when conducting a therapy session with a volunteer client (as measured by the Yulis and Kiesler (1968) measure of personal involvement). In a study of 20 supervisor-therapist trainee dyads, Hayes et al. (1997) found that supervisor ratings of trainees’ empathic abilities were inversely related to negative countertransference-based behavior (as measured by supervisor ratings of behavioral avoidance) such that higher ratings of trainee empathic ability related negatively to responses to clients that were judged by supervisors to inhibit, discourage, or divert further personal exploration or emotional expression (within-therapist effects).

Self-integration. Theoretically, the empathic process of partially and vicariously identifying with one's clients without becoming fused is closely related to the concept of self-integration (Gelso, 2011). Self-integration refers to the therapist's psychological health, such that the therapist possesses a relatively stable and cohesive identity and the capacity to differentiate their needs from the needs of the client (Hayes et al., 1991; Van Wagoner et al., 1991). Self-integration encompasses interpersonal boundaries that are neither rigid and impenetrable nor too permeable. Within the therapeutic relationship, therapist self-integration manifests as the ability to accurately identify and prioritize the client's needs (Gelso, 2011). Conversely, shaky self-integration can lead to the distortion of client material and result in either over or under-involvement with client issues (Gelso & Hayes, 2007).

Hayes et al. (1997) found that supervisor ratings of therapist trainees' level of self-integration related negatively to supervisor ratings of avoidance behavior (within-therapist effects). Likewise, the need for approval and the need to nurture have been shown to moderate therapist's countertransference behavior such that therapists possessing high needs for approval and to nurture were more likely to display countertransference behavior toward their clients as measured by independent ratings of avoidance behavior (Bandura, Lipsher & Miller, 1960; Mills & Abeles, 1965). These findings suggest that therapists who had yet to identify and resolve these areas of personal conflict were less likely to manage their countertransference reactions productively.

Anxiety Management. The fifth and final constituent of countertransference management is the ability to manage anxiety. Anxiety management is conceptualized as the ability to modulate anxiety and to understand its origins (Hayes et al., 1991; Van Wagoner et al., 1991). Because countertransference reactions are often provoked by the therapist's anxiety, they

are generally indicative of a defense. Just as the client's anxiety is a fundamental and inextricable factor in the erection of defenses, the therapist's anxiety is a key part of their countertransference (Gelso, 2011). Theoretically, the most effective therapists are those who allow themselves to experience anxiety without having to erect defenses. In other words, even when combined with other aspects of countertransference management (perhaps most centrally, self-insight), therapists are able to contain their anxiety and use it to better understand the client, deepen the therapeutic relationship, and advance the work of therapy. In general, research supports the hypothesis that therapists who effectively manage anxiety are better able to manage countertransference reactions and in turn, exhibit less countertransference behavior (Gelso et al., 1995; Gelso, Latts, Gomez, & Fassinger, 2002; Hayes & Gelso, 1991; Yulis & Kiesler, 1968). For example, in a sample of 32 supervisor-therapist trainee dyads, Gelso et al. (2002) found that supervisor ratings of trainees' anxiety management were positively related to both supervisor and trainee ratings of client outcomes (within-therapist effects). However, the majority of the research has not explicitly tested for therapist effects.

Countertransference Management and Treatment Outcomes. Meta-analytic findings have confirmed that countertransference management contributes to positive treatment outcomes (Hayes et al., 2011; Hayes et al., 2018). Hayes et al. (2011) found a modest inverse relation between countertransference management and countertransference behavior (r = -.14) and a large positive association between countertransference management and treatment outcomes (r = .56). The strength of these associations varied depending upon how countertransference management was measured and whether supervisors or trainees provided the ratings of countertransference management ability. Specifically, associations between countertransference management and countertransference behavior and treatment outcomes were

stronger when more direct measures of countertransference management were used and when supervisors, as opposed to trainees, rated countertransference management (Hayes et al., 2011). A recently updated meta-analysis including four additional studies similarly found evidence of a modest inverse relationship between countertransference reactions and psychotherapy outcomes (r = -.16); a moderate inverse relationship between countertransference management and countertransference reactions (r = -.27); and a large positive association between countertransference management and psychotherapy outcome (r = .39; Hayes, Gelso, Goldberg, & Kivlighan, 2018). Together, these findings suggest that countertransference management attenuates countertransference reactions and enhances psychotherapy outcomes.

Measures of Countertransference Management

Countertransference Factors Inventory. The research that has been conducted on countertransference management has almost exclusively used the Countertransference Factors Inventory (CFI; Van Wagoner et al., 1991) or a shortened version (CFI-R; Hayes et al., 1991). The CFI was designed to be rated by someone who is familiar with the therapist's work and can indicate the extent to which the therapist possesses the five qualities theorized to facilitate countertransference management (e.g., a supervisor). The CFI consists of 50 items that capture the five qualities in general (Van Wagoner et al., 1991) and the CFI-R consists of 27 items from the CFI that were judged by experts to have strong face and content validity (Hayes et al., 1991). Empirical evidence generally supports the CFI's reliability and validity (Fauth, 2006). For instance, reputedly excellent therapists were rated higher by peers on the CFI than were therapists in general (Van Wagoner et al., 1991). Likewise, therapists in training who were rated higher by their supervisors on the CFI also demonstrated better treatment outcomes (Gelso et al., 2002). Finally, ratings from a sample of 126 current supervisors showed that scores on the CFI-

R were inversely related to negative countertransference, as measured by behaviors that were inappropriately supportive or rejecting of the client (Friedman & Gelso, 2000).

Although findings mostly support the CFI and the five-factor model on which it is based, there are important limitations of the measure. The main limitation, as noted by Fauth (2006), is that the CFI does not directly assess countertransference management. Instead, it reflects the original conception of the five therapist factors as being *facilitative* of managing countertransference (Van Wagoner et al., 1991). More recently, theorists have stressed that the five factors are better seen as *constituents* of countertransference management (Gelso & Hayes, 2007). In an attempt to address this issue, Gelso et al. (2002) selected 21 items from the original CFI that seemed to capture what the therapist is like in session and named the measure the CFI-D (Direct). Although the CFI-D consists of items that pertain to things happening within the treatment hour, the measure still relies on the original CFI items, thus only improving measurement concerns to a small degree. To date, no evidence exists to support the presence of five factors for any version of the CFI. The only study that conducted a factor analysis on the CFI (e. g., Latts 1996) did not find support for the proposed five-factor structure.

Countertransference Management Scale. In light of these limitations, Perez-Rojas et al. (2017) sought to develop an improved measure of countertransference management that would capture the five therapist qualities as constituents (rather than correlates) of countertransference management as they manifest during the psychotherapy hour. Given research suggesting that therapists in training frequently struggle to detect and manage countertransference (Hill et al., 2007; Howard et al., 2006), items were written to be rated by supervisors. Their efforts resulted in the 22-item Countertransference Management Scale (CMS; Perez-Rojas et al., 2017). Exploratory factor analysis of ratings of 286 therapy supervisors of

current supervisees indicated that the five constituents of countertransference management were grouped into two interrelated factors: “Understanding of the Self and the Client” and “Personal Security.” Items comprising the first factor (the “Understanding of the Self and the Client” subscale) reflect the therapist’s self-awareness and ability to understand their thoughts, feelings, behaviors, and motives, as well as how these relate to the client (Perez-Rojas et al., 2017). It also reflects an empathic understanding of the client’s point of view, or an ability to grasp their inner world. Finally, items comprising this factor tap the therapist’s ability to use theory to understand themself, the client, and the dynamics between the two. In combination, the composition of this factor corroborates prior findings suggesting that neither self-awareness nor use of theory alone are sufficient to manage countertransference and that instead the two work in tandem to attenuate countertransference (Latts & Gelso, 1995; Perez-Rojas et al., 2017; Robbins & Jolkovski, 1987).

Items comprising the “Personal Security” subscale reflect a sense of the therapist, within the psychotherapy session, as integrated, composed, aware of boundaries, and able to manage anxiety. Perez-Rojas et al. (2017) observed that, “personal security thus alludes to a sort of inner harmony in the therapist in the treatment hour, which allows them to experience anxiety and related affects without acting out, and to remain secure or grounded in the self and thus be consistent, appropriately confident, and cognizant of where they end and the client begins” (p. 25). This finding is consistent with corresponding theoretical and empirical recommendations that therapists must attend to their own psychological health through active and ongoing self-care (Gelso & Hayes, 2007; Hayes et al., 2011; Perez-Rojas et al., 2017).

As expected, preliminary research examining the validity of the CMS found that scores on the CMS related inversely to countertransference behaviors, as measured by behaviors that

were rejecting of, or inappropriately supportive toward, the client (Perez-Rojas et al, 2017). Moreover, the CMS and its subscales were negatively related to both positive and negative countertransference, suggesting that with successful management, therapists may be better able to handle behaviors that are disapproving of the client (negative countertransference) or inappropriately familiar or supportive (positive countertransference; Perez-Rojas et al., 2017). As the most direct, theoretically derived measure of countertransference management currently available, the CMS was used to measure countertransference management in the current study. Available reliably and validity data for the CMS are reviewed in Chapter 3.

Countertransference Management Among Therapists in Training

Meta-analytic findings have demonstrated that the relationships between countertransference management and countertransference behavior and treatment outcome are weaker when ratings were provided by therapist trainees (Hayes et al., 2011). This is consistent with findings that therapists in training often struggle to appropriately identify, understand, and manage countertransference (Howard et al., 2006). For example, qualitative research with doctoral and masters level trainees revealed that therapists in training often lack many of the skills necessary to effectively manage countertransference, let alone use countertransference therapeutically (Hill et al., 2007; Howard et al., 2006). Indeed, therapists in training identified anxiety about seeing clients, troubling reactions towards clients, difficulties in empathizing with clients, and problems related to self-awareness as significant challenges in the process of becoming a psychotherapist (Hill et al., 2007). Due to their inexperience in navigating these challenges, therapists in training may be particularly vulnerable to act out toward their clients based upon their countertransference reactions (Howard et al., 2006). Accordingly, several scholars have recommended that therapists in training work to develop countertransference

management skills (Fatter & Hayes, 2013; Van Wagoner et al., 1991). How therapists in training might develop these therapeutic skills, however, has yet to be established. To this end, mindfulness has recently been proposed as a potential way to develop the qualities associated with effective therapeutic relating and countertransference management (Bruce et al., 2010; Lambert and Ogles 2004).

Mindfulness and Meditation

Mindfulness Defined

Mindfulness is the English equivalent of the Pali words *sati* and *sampajana*, which can be translated as awareness, circumspection, discernment, and retention (Shapiro & Carlson, 2009). Integrating these various aspects, mindfulness has been defined as "the awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to the unfolding of experience" (Kabat-Zinn, 2003, p. 145). Thus, mindfulness can be understood as both a process (mindful practice) and an outcome (mindful awareness; Shapiro & Carlson, 2009). Although mindfulness has its roots in Buddhist spiritual traditions, mindfulness is further regarded as a naturally occurring and universal human capacity, one that spans across many religious, spiritual, and philosophical traditions (Brown & Cordon, 2008; Shapiro & Carlson, 2009; Walsh, 2000).

Mindful Awareness

Synthesizing spiritual and psychological conceptions of mindfulness, Shapiro and Carlson (2009) suggest that mindful awareness, that is, the awareness that arises through intentionally attending to experience in an open, caring, and nonjudgemental way, is fundamentally a way of being. They stated,

> Mindful awareness is a way of relating to all experience – positive, negative, and neutral – in an open, receptive way. This awareness involves freedom from grasping and wanting anything to be different. It simply knows and accepts what is here, now. Mindfulness is about seeing clearly without one's conditioned patterns of perceiving clouding awareness, and without trying to frame things in a particular way…Thus, mindfulness involves simply knowing what is arising without adding anything to it – without trying to get more of what one wants (pleasure, security), or pushing away what one doesn't want (e.g., fear, anger, shame; Shapiro & Carlson, 2009, p. 5).

Mindfulness allows and accepts the present moment as it is rather than how one might wish for it to be. Yet, mindful awareness is also discerning. This discerning attention affords insight into which experiences lead to greater suffering for oneself and others and which experiences do not. Mindful awareness is a capacity inherent to all human beings; however, this capacity is often clouded by conditioned patterns of thinking, feeling, and behaving (e.g., auto-pilot). To counteract this conditioning, one can train one's mind in the innate capacity to be with and know one's experience as it arises and passes away.

Mindful Practice and Meditation

Theoretically, mindfulness can be systematically cultivated through sustained practice and meditation. Mindful meditation is the intentional practice of observing and shaping the mind, with the mind (Shapiro & Carlson, 2009; Shapiro, Carlson, Astin, & Freedman, 2006). Walsh and Shapiro (2006) define mindful meditation as a family of self-regulation practices that focus on training attention and awareness in order to bring mental processes under greater voluntary control and thereby foster general mental well-being and development and/or specific capacities such as calm, clarity, and concentration. Shapiro et al. (2006), further propose that

mindful meditation is composed of three closely interwoven elements: intention, attention, and attitude.

Intention. The traditional Buddhist intention of freedom from suffering for oneself and for all beings is central to mindful practice. As noted by Jon Kabat-Zinn, "intentions set the stage for what is possible. They remind you from moment to moment why you are practicing in the first place" (Kabat-Zinn, 1990, p. 32). Mindful practice helps people bring unconscious values to awareness; decide whether they are values they really want to pursue (specifically, do they promote well-being or are they merely biological reflexes or culturally conditioned reactions); and develop values and skills that promote well-being and decrease those that do not (Shapiro & Carlton, 2009).

Attention. The second fundamental aspect of mindfulness is attention. Mindfulness meditation involves observing one's moment-to-moment internal and external experience. Attention is critical to the process, such that one moves beyond automatic interpretations and superficial self-knowledge towards a deepening attention and attunement to the contents of one's own consciousness. Mindfulness involves a "dynamic process of learning to cultivate attention that is discerning and nonreactive, sustained and concentrated, so that [one] can see clearly what is arising in the present moment" (Shapiro & Carlson, 2009, p. 10). In essence, one learns to truly listen to oneself.

Attitude. The qualities that one brings to attention comprise the third essential aspect of mindfulness. Whereas attention can at times be cold and analytical, the attitude of mindfulness is one of compassion and warmth. Siegel (2007) identifies curiosity, openness, acceptance, and love (COAL) as the attitudinal foundations of mindfulness. Attending to experience without these attitudes can result in practice that is harsh and judgmental and runs contrary to the basic

intentions of mindfulness. As Shapiro and Carlson (2009) noted, the attitude of mindfulness is not an attempt to make things be a certain way. Rather, the attitude of mindfulness is an attempt to relate to whatever *is* in a certain way. "By intentionally bringing attitudes such as patience, compassion, and non-striving to attentional practice, one relinquishes the habitual tendency of continually striving for pleasant experiences, or of pushing aversive experiences away" (Shapiro & Carlson, 2009, p. 12).

Theorized Benefits of Mindfulness

According to traditional Buddhist teachings, the outcomes of mindfulness meditation are referred to as the four immeasurables: loving kindness, empathic joy, compassion, and equanimity (Bien, 2008; Wallace, 2001). Loving kindness represents the ability to offer happiness and joy to oneself and others (Bien, 2008). Empathetic joy refers to the ability to share in others' happiness, whereas compassion is rooted in a desire to alleviate suffering (Bien, 2008). Lastly, equanimity is defined as an even-natured and balanced form of emotional intelligence that fosters the ability to accept whatever comes (Bien, 2008; Young, 1997). Theoretically, mindfulness meditation enhances the capacity to relate to oneself with loving kindness, empathic joy, compassion, and equanimity and this, in turn, improves the quality of one's relationships with others (Bruce, 2006; Kristeller & Johnson, 2005; Wallace, 2001; Young, 1997). In addition to these intra- and interpersonal benefits, scholars have theorized that mindfulness is associated with a host of psychological benefits including: increases in attention, concentration, self-control, objectivity, emotion regulation, and cognitive flexibility as well as decreases in emotional reactivity, physiological response to stress, and behavioral avoidance (Fulton, 2005; Siegel, 2007a, 2007b, 2012; Shapiro et al., 2006; Walsh & Shapiro, 2006).

Integrating spiritual and psychological conceptualizations of mindfulness with attachment theory, Siegel (2007a) theorized that mindfulness is essentially a state of intrapersonal attunement in which one attends to themself with compassion and kindness and when able to manifest this self-attunement they are better able to attune to others. He has further hypothesized that the process of mindfulness uses the same neural circuitry involved in attuning to the needs of others and building relationships. Identifying notable similarities between an open, accepting, and respectful relationship with the self and an attuned and secure attachment between parent and child, Siegel (2007) asserted that mindfulness can be thought of as the basis of a secure relationship with the self.

Research Support for Mindfulness

Mindfulness and Psychosocial Health. The relationship between mindfulness and psychosocial health has been well documented by a vast body of correlational, controlled intervention, and experimental studies (Keng, Smoski, & Robins, 2011). Research findings have documented significant and positive associations between mindfulness and higher levels of sustained attention, self-control, self-compassion, emotional intelligence, autonomy, mastery, sense of purpose, persistence, and personal growth (Keng et al., 2011). Studies also have reported significant negative associations between mindfulness and psychological distress, neuroticism, difficulties in emotion regulation, dissociation, alexithymia, social anxiety, perceived stress, and rumination (Keng et al, 2011). Based upon their review of these findings, Keng et al. (2011) concluded that mindfulness "brings about various positive psychological effects, including increased subjective well-being, reduced psychological symptoms and emotional reactivity, and improved behavioral regulation" (p. 1041). Of note with respect to the proposed study, mindfulness has also been associated with enhanced interpersonal functioning in

intimate relationships, including increased relationship satisfaction and decreased emotional distress in response to conflict (Barnes, Brown, Krusemark, Campbell, & Rogge, 2007; Dekeyser, Raes, Leijssen, Leyson, & Dewulf, 2008; Wachs & Cordova, 2007).

Mindfulness and Attachment Security. In support of Siegel's (2007a, 2012) conceptualization of mindfulness as the basis of a secure relationship with the self, neurobiological studies of mindfulness and secure attachment often demonstrate a convergence in outcome measures (Parker, Nelson, Epel, & Siegel, 2015). For instance, neurobiological research on mindfulness and secure attachment found that they are both associated with functions in the middle aspects of the prefrontal cortex (mPFC; Siegel, 2007b). Notably, this region of the brain is believed to remain plastic into adulthood and has been found to play a central function in bodily regulation, attuned communication, emotional balance, response flexibility, empathy, insight or self-knowing awareness, morality, intuition, and fear modulation (Siegel, 2007b). These nine outcomes have been associated with secure attachment styles as well as mindfulness training and sustained mindfulness practice (Parker et al., 2015).

Experimental findings indicate that the repeated practice of mindfulness meditation changes the structure and functioning of prefrontal cortex and help to explain how the state of mindfulness intentionally cultivated during meditation becomes an effortless trait over time that serves to alter the relationship to the self (Farb et al., 2007; Siegel, 2007). For example, Farb et al. (2007) used functional magnetic resonance imaging (fMRI) to probe the relationship between mindfulness and dual modes of self-referencing (e.g., extended self-reference linking experience across time and momentary self-reference centered in the present) in a group of novice participants and in a group of participants that attended an 8-week course on mindfulness meditation. Members from both groups participated in tasks designed to activate an experiential

or narrative self-focus while fMRI scans were taken. In novice participants, an experiential focus yielded focal reductions in self-referential cortical midline regions (mPFC) associated with narrative focus. In trained participants, experiential focus resulted in more marked and pervasive reductions in the mPFC, and increased engagement of a right lateralised network, comprising the lateral prefrontal cortex and viscerosomatic areas such as the insula, secondary somatosensory cortex, and inferior parietal lobule, areas of the brain that have been associated with the integration of sensory experiences. Functional connectivity analyses further demonstrated a strong coupling between the right insula and the mPFC in novices that was uncoupled in the mindfulness group. These results are consistent with previous research indicating that a narrative focus is associated with increased ruminative thoughts about the self and that an experiential focus can interrupt rumination by disengaging and re-directing attentional processes of self-referential elaboration (e.g., Watkins and Teasdale, 2001) and suggest a "fundamental neural dissociation between two distinct forms of self-awareness that are habitually integrated but can be dissociated through mindfulness training: the self across time and in the present moment" (Farb et al., 2007, p. 313). Presumably, mindfulness facilitates an acceptance of the self in the present moment, thereby enhancing personal feelings of security, which can then become integrated into one's sense of self across time.

Results from correlational studies on mindfulness and attachment closely parallel neurobiological findings. In the first study to investigate the association between mindfulness and attachment among experienced meditators, Shaver, Lavy, Saron, and Mikulincer (2007) found that self-reported attachment security, as indicated by low attachment avoidance and low attachment anxiety, accounted for up to 42% of the variance in mindfulness, a finding that has since been replicated several times (Goodall, Trejnowska, & Darling, 2012; Pepping, Davis, &

O'Donovan, 2015; Walsh, Balint, Smolira, Frederisksen, & Madsen. 2009). Extending these findings, Pepping, O'Donovan, and Davis (2014) found that the relationship between mindfulness and attachment security was moderated by meditation experience, such that the negative association between attachment anxiety and mindfulness was significantly stronger for experienced meditators than for non-meditating individuals. Taken together with neurobiological findings, these results offer support for Siegel's (2007a, 2012) conceptualization of mindfulness as the basis of secure attachment and mindfulness meditation as a means of cultivating trait mindfulness.

Theorized Application of Mindfulness to Psychotherapy

Siegel (2007) first proposed that mindfulness enhances the therapist's ability to create an attuned relationship with their clients and that attunement is an essential aspect of the therapeutic relationship. Extending this conceptualization, Bruce et al. (2010) further asserted that attunement with the therapist may enhance the client's own self-attunement and its associated psychological and social benefits. Specifically, the therapist's level of mindfulness is thought to affect the client through a process of attunement across three relationships: 1) the therapist's relationship with themself; 2) the therapist's relationship with the client; and 3) the client's relationship with themself (Bruce et al., 2010). Such attunement has been conceptualized as the heart of therapeutic change (Bruce, 2006; Bruce et al., 2010; Siegel, 2007a, 2012).

Therapist Mindfulness and the Therapeutic Relationship. To date, the influence of therapist mindfulness on the therapeutic relationship has received very little empirical attention. Ryan et al. (2012) conducted the only known study examining therapist mindfulness, the working alliance, and treatment outcomes in a sample of 26 therapist-client dyads. Correlational analyses examining within-therapist effects revealed a positive association between therapists'

self-reported mindfulness and ratings of the working alliance at session three ($r = .456$, $p < .05$). The relationship between therapist self-reported mindfulness and client ratings of the working alliance, however, did not reach significance ($r = .219$, $p < 08$). Consistent with Bruce et al.'s (2010) formulation of mindfulness as a three-way process of intra- and interpersonal attunement, therapist mindfulness positively predicted client rated improvements in interpersonal functioning at termination ($r = .481$, $p < .05$). Further empirical attention, therefore, is warranted with respect to both the working alliance and the real relationship between therapist and client.

Theorized Application to Countertransference Management

The therapist's capacity for an open and accepting relationship with themselves (i.e., intrapersonal attunement) is posited to be a crucial precursor to creating an attuned relationship with the client (Bruce et al., 2010). Paralleling Sterba's (1934) concept of the split ego, the ability to attune to oneself suggests "a duality of mind as both the knower and the known" (Bruce et al., 2010, p. 86). In illustration of this concept and its relationship to mindfulness, Bruce et al. (2010) offered the following metaphor:

> Mindful awareness is seen as a bowl and the contents of mind are held within the bowl. Through mindfulness practice, one's bowl is enlarged so that it can hold more intense experience without overflowing. Overflowing means losing mindful awareness – that is – getting lost in experience or pushing it away. Through practice, one begins to identify more with the bowl and less with what is in the bowl. The result is increased self-attunement: knowing and accepting oneself (p. 86).

With respect to the therapeutic relationship, those experiences that the therapist is unable to hold in the "bowl" of awareness can result in countertransference and potentially threaten the work of therapy (Bruce et al., 2010). When the therapist is able to remain present and attuned to the

client's experiences and meet them with openness, empathy, and compassion, it communicates to the client that their suffering is tolerable. As this becomes internalized within the context of the therapeutic relationship, clients can begin to heal their relationship with themselves and with others in their lives. Mindfulness has been proposed as a means for developing countertransference management abilities by expanding the therapist's "bowl of awareness" and promoting a warm and accepting therapeutic presence (Bruce et al., 2010; Fatter & Hayes, 2013; Parker et al., 2015; Siegel, 2007a, 2012). Theoretical conceptualizations of countertransference management as composed of understanding of the self and the client and personal security overlap considerably with Siegel's (2007a, 2007b, 2012) view of mindfulness as the basis of a secure relationship with the self.

Therapist Mindfulness and Countertransference Management. Preliminary empirical findings suggest that mindfulness practices may also help to foster the therapist qualities theorized to constitute countertransference management. For example, Shapiro et al. (2007) found that participation in an 8-week MBSR program was associated with lower stress levels and enhanced emotional regulation among therapists in training. Compared to controls, participants experienced a significant reduction in perceived stress, negative affect, rumination, and state and trait anxiety. Similarly, a 4-year, qualitative study examining the impact of a 15-week MBSR course on counseling graduate students revealed that practicing mindfulness increased awareness and acceptance of personal issues and emotions, mental clarity and organization, a sense of relaxation, tolerance of physical and emotional pain, and the capacity for compassion and empathy (Schure et al., 2008).

Research on therapists with an established meditation practice also point to a meaningful connection between therapist mindfulness and qualities associated with countertransference

management (Keane, 2014; Wang, 2007). Wang (2007) compared meditating and non-meditating therapists on measures of awareness and empathy and found that there were no significant differences between meditating therapists and non-meditating therapists in levels of attention or awareness (Wang, 2007). However, meditating therapists had significantly greater levels of empathy than therapists who did not meditate. Qualitative interviews with meditating therapists revealed that regularly practiced meditation fostered attention and awareness, non-judgmental acceptance, empathy, love, and compassion (Wang, 2007). In another mixed method study conducted by Keane (2014), mindfulness meditation positively related to therapist-rated self-awareness and empathy. Qualitative interviews pointed to meaningful connections between mindfulness meditation, greater awareness of transference and countertransference reactions, and feeling a sense of enhanced interpersonal attunement with one's clients (Keane, 2014).

In the only known study directly examining the relationships among mindfulness, meditation, and countertransference management, Fatter and Hayes (2013) reported evidence that mindfulness and meditation may facilitate countertransference management. In a sample of 76 therapist trainee-supervisor dyads, trainee reported dispositional mindfulness, meditation experience, and self-differentiation predicted supervisor ratings of countertransference management abilities; however, years of meditation experience was the only significant and unique predictor of countertransference management ability. Pairwise comparisons revealed that years of meditation experience was significantly and positively correlated with supervisor ratings of self-insight, self-integration, empathy, and overall countertransference management ability. The frequency and duration of meditation per week was significantly correlated with self-insight. Among the various facets of mindfulness, only non-reactivity was predictive of countertransference management ability (i.e., self-insight, self-integration, empathy, and anxiety

management). These findings have yet to be replicated and to the best of our knowledge, have never been examined in relationship to the real relationship and working alliance.

Limitations and Methodological Considerations in the Measurement of Mindfulness

Empirical investigations into the nature and effects of mindfulness have been limited by difficulties in reliably quantifying the construct of mindfulness. Two considerations feature prominently in on-going theoretical and methodological debates over how to operationalize and measure mindfulness: 1) the multidimensional and subjective nature of mindfulness and 2) the often-assumed equivalence between the capacity for mindfulness (i.e., dispositional or trait mindfulness) and the mindful state of awareness that is cultivated through mindful meditation (Rau & Williams, 2016). Empirical findings relevant to these considerations and their implications for research in general and the proposed study in particular will be further discussed.

In their review of construct validation research, Rau and Williams (2016) found that analyses of several mindfulness measures support a multidimensional structure emphasizing both the nature and quality of present moment attention. Citing additional findings that various facets of mindfulness are dissociable (e.g., Eisenlohr-Moul, Walsh, Charnigo, Lynam, & Baer, 2012), Rau and Williams (2016) cautioned researchers against using a summary score to represent mindfulness and instead encouraged them to examine interactions at the facet level. Rau and Williams (2016) further warned that if mindfulness is indeed multidimensional, as both theory and empirical findings suggest, the variance introduced by each lower-level construct could reduce the precision of single score interpretations (Rau & Williams, 2016).

Empirical findings also indicate that dispositional or trait mindfulness and a cultivated state of mindfulness are two conceptually distinct and meaningful constructs, each of which

requires separate operational definitions and measurement instruments (Rau & Williams, 2016). Generally, empirical findings have confirmed that mindfulness is a universally occurring dispositional trait (Brown & Ryan, 2004; Goldstein, 2002; Kabat-Zinn, 2003; Rau & Williams, 2016). However, there is also evidence to suggest that mindfulness is manifested differently depending upon one's exposure to mindfulness training and practice. For example, different response patterns to measures of dispositional mindfulness have been observed between samples trained in mindfulness versus those who have not (Baer et al., 2008; Christopher et al., 2009).

Paradoxically, individuals without mindfulness training reported higher levels of dispositional mindfulness compared to those just beginning a mindfulness practice (Baer et al., 2008). Researchers have theorized that high scores could reflect overestimation by individuals with little experience or knowledge of mindfulness and low to average scores could reflect more modest or realistic accounts by individuals with a greater knowledge and understanding of mindfulness (Baer et al., 2008). Still other research has found that mindfulness experienced during meditation is unrelated to mindfulness experienced in everyday life (Carmody, Reed, Kristeller, & Merriam, 2008; Thompson &Waltz, 2007). In light of these theoretical and empirical considerations, Rau and Williams (2016) recommended that researchers gather and discuss sample characteristics, in particular the type and degree of mindfulness training, when reporting and interpreting research findings.

Based upon the findings and recommendations described above, the current study operationalized dispositional mindfulness as a multidimensional construct characterized by the following facets: 1) observing; 2) describing; 3) acting with awareness; 4) being non-judging of inner experience; and 5) being non-reactive to inner experience. Additionally, information about

therapist trainees' exposure to mindfulness meditation and practice was collected, including the type, frequency, and duration of their mindfulness-based practice.

Chapter III: Methodology

Participants

A total of 140 eligible therapists in training responded to the online survey. Of these respondents, 87 therapists in training provided contact information for their current clinical supervisor. Seventy-six individual supervisors responded to the survey, comprising a total of 77 unique therapist-trainee and supervisor dyads. Of these 77 dyads, there were three incomplete sets of data, such that two therapists in training provided ratings of the real relationship and working alliance for only one client and another therapist in training provided ratings of the real relationship and working alliance for only two clients. For these therapists in training, mean ratings of the real relationship and the working alliance were computed based upon the number of complete ratings provided and included in study analyses.

Therapists in Training. Of the 77 therapists in training, 59 (76.7%) self-identified as women, 16 (20.8%) self-identified as men, and 2 (2.7%) self-identified as non-binary. Ages among therapists in training ranged from 22 to 48 years old with a mean age of 28.92 (*SD = 4.90, N = 72).* With respect to race/ethnicity, 61 (79.2%) therapists in training identified as "White, Caucasian, or European American," 5 (6.8%) identified as "Black or African American," 4 (5.4%) identified as "Asian or Asian American," 3 (4.1%) identified as "Hispanic or Latino," and 3 (4.1%) identified as both "Hispanic or Latino" and "White, Caucasian, or European American." In terms of religious and spiritual identification, 27 (35.1%) therapists in training indicated that they did not identify as religious or spiritual, 29 (37.7%) therapists in training identified themselves as somewhat religious or spiritual, and 21 (27.3%) therapists in training identified themselves as religious or spiritual. Of the 26 therapists in training who identified their specific religious/spiritual beliefs and practices, qualitative responses were

diverse and inclusive of the following religious and spiritual traditions: Spiritual but not Religious, Non-denominational Christianity, Catholicism, Judaism, Protestantism, Seventh Day Adventistism, Agnostic, Existentialism, Buddhism, Mindfulness and Meditation, Connection to Humanity and Nature, and Individual Prayer and Church Service.

With respect to graduate training, 9 (11.7%) were masters students, 39 (50.6%) were doctoral students, 27 (35.1%) were predoctoral interns, and 2 (2.6%) were post-doctoral fellows in an accredited clinical or counseling psychology training program. Among masters students, years of graduate training ranged from one year to three years; 5 (55.6%) therapists in training had one year of graduate training, 2 (22.2%) had two years, and 2 (22.2%) had three years. In terms of direct clinical experience, 5 (55.6%) reported that they had less than one year of clinical experience and 4 (44.4%) reported that they had one year of clinical experience. Among doctoral students, pre-doctoral interns, and post-doctoral fellows, years of graduate training ranged from one year to five or more years; 4 (6.0%) therapists in training had one year of graduate training, 8 (8.0%) had two years, 10 (14.9%) had three years, 16 (23.9%) had four years, and 29 (43.3%) had five or more years of graduate training in clinical or counseling psychology. In terms of direct clinical experience, 7 (10.4%) reported that they had less than one year of clinical experience, 1 (1.5%) reported that they had one year of clinical experience, 10 (14.9%) reported that they had two years of clinical experience, 16 (23.9%) reported that they had three years of clinical experience, 21 (31.3%) reported that they had four years of clinical experience, and 12 (17.9%) reported that they had five or more years of clinical experience.

Therapists in training espoused a variety of theoretical orientations. Of those who identified a single theoretical orientation (n = 55, 71.4%), therapists in training identified cognitive behavioral (n = 32, 41.6%), psychodynamic (n = 6, 7.8%), acceptance and commitment

(n = 6, 7.8%), family systems (*n* = 2, 2.6%), humanistic (*n* = 2, 2.6%), time-limited dynamic (*n* = 2, 2.6%), behavioral (*n* = 1, 1.3%), client-centered (*n* = 1, 1.3%), emotion-focused (*n* = 1, 1.3%), existential (*n* = 1, 1.3%), and third-wave behavioral (*n* = 1, 1.3%) as their primary theoretical orientation. Another 20 (26.0%) therapists in training identified as eclectic or integrative and incorporated combinations of cognitive behavioral, acceptance and commitment, dialectical behavioral, developmental, person-centered, humanistic, existential, feminist, psychodynamic, interpersonal/relational, and trauma-informed approaches. Only two (2.6%) therapists in training identified their theoretical orientation as undecided or unknown.

Current clinical placements spanned several treatment settings. Of the 77 therapists in training included in the study, 59 (76.6%) reported that they saw clients in one treatment setting: 19 (24.7%) in a university counseling center, 11 (14.3%) in a hospital setting, 7 (9.1%) in a community counseling center, 6 (7.8%) in an outpatient clinic, 1 (1.3%) in a forensic setting, and 15 (19.5%) in other specified treatment settings. Other specified treatment settings include an at-risk teen program, primary care behavioral health, pediatric primary care, graduate training clinics, inpatient or residential substance use treatment programs, VA Medical Centers, intensive outpatient treatment programs, clinical research, and a homeless shelter. The other 18 (23.4%) therapists in training saw clients in two or more of the treatment settings listed above. The reported number of direct clinical hours ranged from 1 to 25 hours per week with a mean of 9.63 direct clinical hours per week (*SD* = 5.10, *N* = 77).

With respect to supervision, the number of supervision hours reported by therapists in training ranged from 1 to 8 hours of supervision per week with a mean of 3.06 hours of supervision per week (*SD* = 1.50, *N* = 76). The majority of therapists in training received direct observation of their clinical work by their clinical supervisors (*n* = 66, 85.7%). Of the 77

therapists in training, only 11 (14.3%) received no direct observation of their clinical work. Therapists in training rated the quality of their supervision on a 5-point Likert-type scale ranging from "Very Poor" to "Excellent" such that higher scores indicated a higher rating of their supervision. Scores ranged from 2 to 5 with a mean score of 4.53 (SD = .70, N = 77).

Of the 77 therapists in training, 66 (85.7%) reported that they were currently in or had previously been in psychotherapy and 11 (14.3%) reported that they had never been in psychotherapy. Only 19 (24.7%) of 77 therapists in training reported that a clinical supervisor had recommended that they seek individual psychotherapy. Of those 19, nine (11.7%) therapists in training reported that they sought individual therapy at the recommendation of a clinical supervisor. In terms of self-care activities, 50 (64.9%) therapists in training reported that they regularly engage in stress reduction and relaxation exercises like yoga, tai-chi, or progressive muscle relaxation. Conversely, 27 (35.1%) therapists in training reported that they did not regularly engage in any of the stress reduction or relaxation exercises listed above.

Therapists in training varied in terms of their mindfulness meditation experience. Of the 77 therapists in training included in the study, 28 (36.4%) reported that they do not practice mindfulness meditation, 29 (37.7%) reported that they sometimes practice mindfulness meditation, and 20 (26.0%) reported that they regularly practice mindfulness meditation. Of the 49 (63.7%) therapists in training with a mindfulness meditation practice, 9 (11.7%) reported that they have been practicing mindfulness meditation for less than one year, 23 (29.9%) reported that they have been practicing mindfulness meditation for one to three years, 9 (11.7%) reported that they have been practicing mindfulness meditation for three to five years, 5 (6.5%) reported that they have been practicing mindfulness meditation for five to ten years, and 3 (3.9%) reported practicing mindfulness meditation for ten years or more.

Supervisors. The sample of 76 supervisors was composed of 56 (73.7%) self-identified women and 20 (26.3%) self-identified men. Ages among supervisors ranged from 27 to 81 years old with a mean age of 43.88 (*SD = 11.25, N = 69).* Of the 76 supervisors, 64 (84.2%) identified as "White, Caucasian, or European American," 4 (5.3%) identified as "Asian or Asian American," 2 (2.6%) identified as "Black or African American," 2 (2.6%) identified as "Hispanic or Latino," 1 (1.3%) identified as "Mixed", and 1 (1.3%) identified as "West Indian." With respect to their religious and spiritual identification, 24 (31.6%) supervisors indicated that they did not identify as religious or spiritual, 25 (32.9%) supervisors identified themselves as somewhat religious or spiritual, and 26 (34.2%) supervisors identified themselves as religious or spiritual. Of the 27 supervisors who identified their specific religious/spiritual beliefs and practices, qualitative responses were diverse and inclusive of the following religious and spiritual traditions: Spiritual but not Religious, Faith-based Reflection, A Course in Miracles, Non-denominational Christianity, Catholicism, Judaism, Protestantism, Episcopalian, United Methodist, Agnostic, Buddhism, Hinduism, Daoism, Mindfulness and Meditation, and Individual Prayer.

With respect to their experience as licensed psychologists, 7 (9.2%) supervisors reported that they were not yet licensed, 6 (7.9%) supervisors reported that they had one to three years of experience, 12 (15.8%) supervisors reported that they had three to five years of experience, 15 (19.7%) supervisors reported that they had five to ten years of experience, and 36 (47.4%) supervisors reported that they had ten years or more of experience. Theoretical orientation varied widely across supervisors. Of those who identified a single theoretical orientation (n = 51, 67.1%), supervisors identified cognitive behavioral (n = 18, 23.7 %), psychodynamic (n = 8, 10.5%), interpersonal (n = 7, 9.2%), acceptance and commitment (n = 6, 7.9%), humanistic (n =

2, 2.6%), developmental (*n* = 2, 2.6%), emotion-focused (*n* = 2, 2.6%), existential (*n* = 1, 2.6%), dialectical behavioral (*n* = 1, 1.3%), Adlerian (*n* =1, 1.3%), systems (*n* = 1, 1.3%), reality therapy (*n* = 1, 1.3%), and behavioral (*n* = 1, 1.3%) as their primary theoretical orientation. Another 22 (28.9%) supervisors identified as eclectic or integrative incorporating various combinations of cognitive behavioral, acceptance and commitment, dialectical behavioral, developmental, narrative, art therapy, mindfulness, emotion-focused, humanistic, person-centered, existential, multicultural, systems, psychodynamic, interpersonal/relational, and trauma-informed approaches. Three (3.9%) supervisors did not identify their theoretical orientation.

Treatment settings were similarly diverse. Of the 76 supervisors included in the study, 64 (84.2%) reported that they saw clients in one of the following treatment settings: 20 (26.3%) in a university counseling center, 13 (17.1%) in a hospital setting, 5 (6.6%) in a community counseling center, 14 (18.4%) in an outpatient clinic, and 12 (15.8%) in another specified treatment settings. Other specified treatment settings included: graduate training programs/training clinics, sliding scale fee clinics, academic medical centers, drug and alcohol treatment programs, intensive outpatient and residential treatment programs, home-based care, hospice care, a nursing home, and private practice. The remaining 12 (15.8%) supervisors saw clients in some combination of the treatment settings listed above. The reported number of supervisors' direct clinical hours ranged from 0 to 35 hours per week with a mean of 13.35 direct clinical hours per week (*SD* = 10.22, *N* = 74).

With respect to supervision, five (6.6%) supervisors reported that they had no formal training in clinical supervision. Of those with formal training in clinical supervision, 18 (23.7%) reported that they had less than one year of training, 35 (46.1%) reported that they had one to three years of training, 8 (10.5%) reported that they had three to five years of training, 4 (5.3%)

reported that they had five to ten years of training, and 5 (6.6%) reported that they had ten years or more of training in supervision. In terms of the type of supervision training received, 17 completed either independent reading (*n* = 9, 11.8%), coursework in supervision (*n* = 4, 5.3%) or a combination of the two (*n* = 4, 5.3%). Another six (7.9%) supervisors received individual supervision of supervision (*n* = 1, 1.3%), group supervision of supervision (*n* = 1, 1.3%), live observation of their supervision (*n* =1, 1.3%), a combination of individual and group supervision of supervision (*n* = 2, 2.6%), or a combination of group supervision of supervision and videotape review of supervision (*n* = 1, 1.3%). Six (7.9%) supervisors received a combination of coursework and one or more forms of supervision of supervision (i.e., individual, group, or live observation of supervision). Eight (10.5%) supervisors reported a combination of independent reading and one or more forms of supervision of supervision (i.e., individual, group, and/or live observation). Two (2.6%) supervisors received a combination of independent reading, videotape review of supervision, and one or more forms of supervision of supervision (i.e., individual, group, and/or live observation). An additional 11 (14.5%) supervisors reported a combination of coursework, independent reading, and one or more forms of supervision of supervision (i.e., individual, group, or live observation of supervision). Another 24 (31.6%) received a combination of coursework, independent reading, video review of supervision, and one or more forms of supervision of supervision (i.e., individual, group, or live observation). Of the 76 supervisors included in the sample, 15 (19.7%) supervisors reported that they were currently receiving some form of individual or group supervision of supervision.

In terms of actual supervisory experience, 26 (34.2%) supervisors had ten years or more of experience, 17 (22.4%) supervisors had five to ten years of experience, 22 (28.9%) supervisors had three to five years of experience, 10 (13.2%) supervisors had one to three years

of experience, and 1 (1.3%) had less than one year of experience. The average number of hours per week spent providing individual or group supervision ranged from 1 to 20, with a mean of 4.81 (*SD* = 4.00, *N* = 75).

With respect to the therapist in training included in the study, 6 (7.8%) supervisors reported that they met for one hour of supervision every two weeks, 39 (50.6%) reported that they met for supervision one hour per week, and 32 (41.6%) reported that they met for supervision for two or more hours per week. Supervisors also were asked to provide an approximate estimate of how long they had been supervising the therapist in training; 17 (22.4%) reported that they had supervised the therapist in training for less than three months, 35 (46.1%) reported that they had supervised the therapist in training for three to six months, 11 (13.2%) reported that they had supervised the therapist in training for six to nine months, 5 (6.6%) reported that they had supervised the therapist in training for nine to twelve months, and 8 (10.5%) reported that they had supervised the therapist in training for one year or more. The majority of supervisors (*n* = 67, 87%) had directly observed the therapist in training's clinical work via co-therapy, live observation, videotape review, audiotape review, or some combination of the aforementioned. Sixteen (20.8%) supervisors estimated that they had observed one to three client sessions, 16 (20.8%) supervisors estimated that they had observed three to five client sessions, 15 (19.5%) supervisors estimated that they had observed five to ten client session, and 19 (24.7%) supervisors estimated that they had observed ten or more client sessions. Supervisors rated the quality of the supervisory relationship on a 5-point Likert-type scale ranging from "Very Poor" to "Excellent" such that higher scores indicated a higher rating of the supervisory relationship. Scores ranged from 3 to 5, with a mean of 4.38 (*SD* = .63, *N* = 77).

Of the 76 supervisors, 66 (86.8%) reported that they were currently in or had previously been in psychotherapy and 10 (13.2%) reported that they had never been in psychotherapy. Seven (9.2%) of the 76 supervisors reported that a clinical supervisor had recommended that they seek individual psychotherapy and reported that they sought individual therapy at the recommendation of a clinical supervisor. In contrast, 47 (61.8%) supervisors indicated that they had recommended that a trainee under their supervision seek their own personal psychotherapy. With respect to the therapist in training included in the study, supervisors had referred five (6.5%) of them to individual psychotherapy.

In terms of stress reduction and relaxation exercises, 34 (44.7%) supervisors reported that they regularly engage in yoga, tai-chi, or progressive muscle relaxation. Of the 76 supervisors included in the study, 22 (28.9%) reported that they do not practice mindfulness meditation, 24 (31.6%) reported that they sometimes practice mindfulness meditation, and 30 (39.5%) reported that they regularly practice mindfulness meditation. Of the 54 (71.1%) supervisors with a mindfulness meditation practice, 4 (5.3%) reported that they have been practicing mindfulness meditation for less than one year, 14 (18.4%) reported that they have been practicing mindfulness meditation for one to three years, 9 (11.8%) reported that they have been practicing mindfulness meditation for three to five years, 13 (17.1%) reported that they have been practicing mindfulness meditation for five to ten years, and 13 (17.1%) reported practicing mindfulness meditation for ten years or more.

Instruments

The measures were presented to therapists in training and supervisors in the same order that the instruments are presented in this section. The choice to order these measures was deliberate such that thought regarding the progression of how the measures fit together and the

flow of the study was considered. For therapists in training, the demographic questionnaire, including items assessing experience with meditation, was administered first, followed by the measure of trait mindfulness. Participants were then instructed to identify three clients they recently met with for psychotherapy and with whom they have met with for at least five individual sessions and asked to complete items assessing the real relationship and working alliance for each of these respective clients. Supervisors completed the demographic questionnaire followed by the countertransference management measure.

Therapists In Training.

Demographics. Demographic information was collected to examine a number of variables. Gender, age, race/ethnicity, religious/spiritual affiliations, and educational history were collected. Therapists in training were asked specific questions regarding their theoretical orientation, current field placement, hours of individual therapy conducted per week, frequency and quality of clinical supervision, exposure to and experience with mindfulness-based practices like meditation, yoga, and/or tai chi, and participation in their own personal therapy. Additional information regarding their mental health history and self-care activities was obtained. For a complete list of demographic questions, please refer to Appendix A.

Mindfulness. Mindfulness was measured using the 39-item, self-report Five Facet Mindfulness Questionnaire (FFMQ; Baer et al., 2006). Developed by Baer et al. (2006), the FFMQ assesses five distinct facets of mindfulness: observing, noticing, and attending to sensations, perceptions, thoughts, and feelings (8 items); describing and labeling with words (8 items); acting with awareness, automatic pilot, concentration, or distraction (8 items); non-judging of inner experience (8 items); and non-reactivity to inner experience (7 items). Sample items of each subscale include: “When I’m walking, I deliberately notice the sensations of my

body moving" (observing); "I can easily put my beliefs, opinions, and expectations into words" (describing); "I don't pay attention to what I'm doing because I'm daydreaming, worrying, or otherwise distracted" (acting with awareness); "I tell myself that I shouldn't be thinking the way I'm thinking" (non-judging); and "I perceive my feelings and emotions without having to react to them" (non-reactivity). Participants are asked to rate how well each statement describes them in general on a Likert-type scale, with responses ranging from 1 (*Never or very rarely true*) to 5 (*Very often true or always true*). Negatively worded items are reverse scored and items are summed yielding both subscale and total scores. Scores for the Observe, Describe, Act with Awareness, and Non-judge subscales range from 8 to 40; scores for the Non-reactive subscale range from 7 to 35, and scores for the total scale range from 39 to 195. In all cases, higher scores reflect greater mindfulness.

There is considerable evidence of the FFMQ's convergent and discriminant validity. The initial validation study found that FFMQ subscale scores correlated as expected with openness to experience (Observe = .42; Describe = .19; and Non-reactive = .18, $p < .001$), emotional intelligence (Observe = .22; Describe = .60; Act with Awareness = .31; Non-judge = .37; and Non-reactive = .21, $p < .001$) and self-compassion (Observe = .14; Describe = .30; Act with Awareness = .40; Non-judge = .48; and Non-reactive = .53, $p < .001$; Baer et al., 2006). Conversely, FFMQ subscale scores negatively correlated with psychological symptoms (Describe = -.27; Act with Awareness = -.48; Non-judge = -.50; and Non-reactive = -.31, $p < .001$), neuroticism (Describe = -.23; Act with Awareness = -.44; Non-judge = -.55; and Non-reactive = -.35, $p < .001$), thought suppression (Describe = -.23; Act with Awareness = -.36; Non-judge = -.56; and Non-reactive = -.22, $p < .001$), difficulties in emotion regulation (Describe = -.38; Act with Awareness = -.40; Non-judge = -.52; and Non-reactive = -.36, p

< .001), alexithymia (Describe = -.68; Act with Awareness = -.42; Non-judge = -.34; and Non-reactive = -.19, $p < .001$), dissociation (Describe = -.32; Act with Awareness = -.62; and Non-judge = -.49, $p < .001$), experiential avoidance (Describe = -.23; Act with Awareness = -.30; Non-judge = -.49; and Non-reactive = -.39, $p < .001$), and absent-mindedness (Describe = -.28; Act with Awareness = -.61; Non-judge = -.41; and Non-reactive = -.15, $p < .001$; Baer et al., 2006). It is of note that, contrary to predictions, the Observe facet was positively associated with psychological symptoms ($\alpha = .17$), thought suppression ($\alpha = .16$), dissociation ($\alpha = .27$), and absent-mindedness ($\alpha = .16$; Baer et al., 2006). When recalculated in a subsample of participants with meditation experience, these four unexpected positive correlations were non-significant, whereas all other correlations remained unchanged or became significantly larger in the predicted direction. These findings suggest that people without meditation experience may tend to observe their internal experiences in a judgmental or reactive way that is inconsistent with mindfulness.

Subsequent research examining the construct validity and reliability of the FFMQ in meditating and non-meditating samples found additional support for this hypothesis (Baer et al., 2008). Correlations among FFMQ subscales and various aspects of psychological well-being as measured by the Psychological Well-being Scales (PWB; Ryff, 1989) were significant and positive across meditating and non-meditating samples, except for the Observe facet (Baer et al., 2008). The Observe facet was significantly correlated with psychological well-being in meditators only. The four other mindfulness facets accounted for 39% of the variance in psychological well-being (Baer et al., 2008). Across meditating and non-meditating samples, the FFMQ total and subscale scores demonstrate adequate to good internal reliability, ranging from .72 to .92 (Baer et al., 2006; Baer et al., 2008; Bowlin & Baer, 2012). Among therapists in

training, reported reliability estimates range from .84 to .92 (Fatter & Hayes, 2013). In the current study, the FFMQ and its subscales had good to excellent internal consistency reliability with alpha coefficients as follows: FFMQ Total = .92; Observe subscale = .79; Describe subscale = .88; Act with Awareness subscale = .84; Non-judge subscale = .95; Non-reactive subscale = .82.

The Real Relationship. The real relationship between the therapist and client was assessed using the Real Relationship Inventory-Therapist Form (RRI-T; Gelso et al., 2005). The RRI-T is a 24-item, self-report measure that assesses the strength of the real relationship from the therapist's perspective. Respondents rate items pertaining to the self (therapist; 6-items), the other (client; 11-items), and their relationship (7-items) on a scale ranging from 1 (*Strongly Disagree*) to 5 (*Strongly Agree*).

The RRI-T is composed of two 12-item subscales: genuineness and realism. Genuineness is defined as "the ability to be who one truly is, to be non-phony, to be authentic in the here and now" (Gelso, 2002, p. 37). Realism is defined as "the experiencing or perceiving of the other in ways that befit them, rather than as projections of wished for or feared others (i.e., transference)" (Gelso, 2002, p. 37). Items on each subscale capture the magnitude (i.e., how much) and the valence (i.e., how positive vs. negative) of the real relationship. Sample items from the genuineness subscale include: "I have difficulty being honest with my client"; "There is no genuinely positive connection between us"; and "We feel a deep and genuine caring for one another." Sample items from the realism subscale include: "I do not like my client as a person"; "My client has respect for me as a person"; and "I feel there is a "real" relationship between us aside from the professional relationship." Negatively worded items are reverse scored and summed, such that higher scores on the RRI-T reflect stronger ratings of the real relationship.

Scores for the genuineness and realism subscales range from 12 to 60; scores for the total scale range from 24 to 120, such that higher scores indicate greater genuineness and realism and a stronger real relationship, respectively.

The RRI-T demonstrates excellent convergent, discriminant, and predictive validity (Fuertes et al., 2007; Gelso et al., 2005; Kivlighan, Jr. et al., 2015; Lo Coco et al., 2011; Marmarosh et al., 2009). Consistent with Gelso and Carter's tripartite model of the therapeutic relationship, the RRI-T positively related to therapist ratings of the working alliance, client ratings of the depth and smoothness of therapy sessions, and client displays of intellectual and emotional insight (Gelso et al., 2005). The RRI-T negatively related to negative transference (Gelso et al., 2005). As theorized, therapists' perceptions of themselves, their clients, and the relationship as genuine and real early in treatment accounted for a significant amount of variance in post-treatment symptoms above and beyond that accounted for by the working alliance (Fuertes et al., 2007; Marmarosh et al., 2009). Across various samples of professional clinicians and therapists in training, reliability estimates for the RRI-T total scale and genuineness and realism subscales have been demonstrated to range from .79 to .94 (Fuertes et al., 2007; Gelso et al., 2005; Kivlighan, Jr. et al., 2015; Lo Coco et al., 2011; Marmarosh et al., 2009).

In the current study, the RRI-T was shortened from 24 items to 12 items in order to reduce participant burden. In order to retain a similar structure and composition to the full scale, six items from each of the Genuineness and Realism subscales, both negatively and positively worded items, and a balance of items assessing perceptions about the self, the client, and therapeutic relationship were included in the shortened 12-item scale. Mean RRI-T scores across therapist ratings of three individual clients were computed to maximize therapist level variance and minimize client level variance. The shortened RRI-T total scale and subscales demonstrated

good internal consistency reliability. For therapist ratings of individual clients, total scale internal consistency reliability coefficients ranged from .81 to .91; alphas for the Genuineness subscale ranged from .72 to .81; and alphas for the Realism subscale ranged from .70 to .87. When items were averaged across all three clients, internal reliability estimates were as follows: Total = .88; Genuineness = .79; Realism = .80.

The Working Alliance. Therapist perceptions of the working alliance between therapist and client was measured using the Working Alliance Inventory-Short Revised (WAI-SR; Hatcher & Gillaspy, 2006). The WAI-SR is a 12-item, self-report measure designed to assess the working alliance construct proposed by Bordin (1979). Bordin (1979) theorized that a working alliance common to all therapeutic relationships would grow out of client–therapist agreement on therapy goals, agreement on therapy tasks, and development of a strong relational bond between client and therapist. Accordingly, the WAI-SR is composed of three subscales assessing the Therapeutic Goals (4 items), Tasks (4 items), and Bond (4 items). Sample items of each respective subscale include: "My client and I collaborate on setting goals for therapy"; "I feel confident that the things we do in therapy will help my client accomplish the changes that they desire"; and "My client and I respect each other." Items are rated on a Likert-type scale ranging from 1 (*Never or very rarely true*) to 5 (*Very often or always true*). Scores for each subscale range from 4 to 20; scores for the total scale range from 12 to 60, with higher scores reflective of stronger working alliance.

The WAI-SR was adapted from the original 36-item Working Alliance Inventory (WAI; Horvath & Greenberg, 1986; 1989) using item response theory and correlations between the shortened measure, the original measure, and other measures of the alliance and outcome (Alexander & Luborsky, 1986; Hatcher & Gillaspy, 2006; Marmar, Horowitz, Weiss, &

Marziali, 1986). In comparison to the WAI and a previous short version of the WAI (WAI-S; Tracey & Kokotovic, 1989), the WAI-SR demonstrates a clearer representation of the alliance and an improved model fit in confirmatory factor analysis by excluding negatively worded items (Hatcher & Gillaspy, 2006). The WAI-SR demonstrates an acceptable model fit for the Bond-Task-Goal model, a superior fit as compared to rivaling models, and lower scale intercorrelations than the WAI and WAI-S (Hatcher & Gillaspy, 2006; Munder et al., 2010). The WAI-SR also demonstrates evidence of good convergent validity, correlating as expected with the Helping Alliance Questionnaire (Luborsky, 1976) and the California Psychotherapy Alliance Scale (Gaston & Marmar, 1994; Hatcher & Gillaspy, 2006). Internal consistency coefficient estimates ranged from .80 to .93 in various clinical samples (Hatcher & Gillaspy, 2006; Kivlighan, Jr. et al., 2016; Munder et al., 2010).

Mean WAI-SR scores across therapist ratings of three individual clients were computed to maximize therapist level variance and minimize client level variance. In the current study, the WAI-SR total scale and subscales demonstrated good to excellent internal consistency reliability. For therapist ratings of individual clients, internal consistency reliability estimates ranged from .89 to .94 for the WAI Total scale; .84 to .93 for the Goals subscale; .79 to .89 for the WAI Tasks subscale; and .77 to .83 for the WAI Bond subscale. When items were averaged across all three clients, internal consistency reliability estimates were as follows: Total = .92; Goals = .86; Tasks = .83; Bond = .83.

Supervisor Measures.

Demographics. In addition to information on gender, age, race/ethnicity, religious/spiritual affiliations, and educational history, supervisors were asked specific questions regarding their theoretical orientation, years of clinical and supervisory experience, duration and

quality of the supervisory relationship, exposure to and experience with mindfulness-based practices like meditation, yoga, and/or tai chi, and participation in their own personal therapy. Additional information regarding their mental health history and self-care activities was also obtained. For a complete list of demographic questions, please refer to Appendix E.

Countertransferense Management. Therapist ability to manage countertransference, as rated by their supervisors, was measured using the Countertransference Management Scale (CMS; Perez-Rojas et al., 2017). The CMS is based upon the five therapist qualities theorized to constitute countertransference management (e.g., self-insight, conceptualizing ability, empathy, self-integration, and anxiety management) and is composed of 22 items comprising two subscales: Understanding of the Self and Client (12 items) and Personal Security (10 items). The Understanding of the Self and Client subscale reflects the therapist's self-awareness, empathic understanding of the client's point of view, and ability to conceptualize oneself, the client, and the dynamics between one another. Sample items include: "Understands the basis of their feelings, thoughts, and behaviors in session" and "Effectively sorts out how their feelings relate to clients' feelings." The Personal Security subscale reflects the therapist's psychological stability (e.g., self-integration, self-confidence, consistency, etc.), possession of appropriate boundaries, and an ability to experience, regulate, and contain anxiety during psychotherapy. Sample items include: "Demonstrates calm in the face of difficult client material" and "Allows themself to feel a range of affect without getting overly anxious."

Supervisors are asked to rate their supervisees on a Likert-type scale ranging from 1 (*Strongly disagree*) to 5 (*Strongly agree*). Scores for the Understanding of the Self and Client subscale range from 12 to 60, scores for the Personal Security subscale range from 10 to 50, and

scores for the total scale range from 22 to 110, with higher scores reflecting greater countertransference management abilities.

There is preliminary evidence for the validity and reliability of the CMS (Perez-Rojas et al., 2017). Perez-Rojas et al. (2017) found that supervisor ratings on the *Understanding of the Self and the Client* and the *Personal Security* subscale scores are significantly and positively correlated with one another (r = .72) and the CMS total score (USC = .94; PS = .91) as well as with supervisor ratings of supervisee theoretical framework (Total = .66; USC = .67; PS = .55, p < .001), self-esteem (Total = .49; USC = .36; PS = .57, p < .001), tolerance of anxiety in their work with clients (Total = .69; USC = .59; PS = .70, p < .001), empathy (Total = .79; USC = .78; PS = .67, p < .001), and self-reflective functioning (Total = .86; USC = .79; PS = .82, p < .001). Consistent with theory, measures of theoretical framework and empathy related most strongly to the *Understanding of the Self and the Client* subscale while measures of self-esteem and tolerance of anxiety correlated most strongly with the *Personal Security* subscale. Moreover, CMS total and subscales scores are inversely related to both positive (Total = -.58; USC = -.51; PS = -.59, p < .001), and negative (Total = -.56; USC = -.53; PS = -.52, p < .001) countertransference behavior as rated by supervisors, supporting the hypothesis that therapists who are better able to manage countertransference are less likely to behave in countertransferential ways. Reported internal reliability coefficients of the CMS total and subscale scores ranged from .93 to .95 (Perez-Rojas et al., 2017). In the current study, one item from the 11-item Understanding of the Self and Client subscale was left out from the survey in error (i.e., “Supervisee uses their theoretical understanding of clients to inform the work during the therapeutic hour”). Internal consistency reliability estimates for the 21-item CMS used in the

study were as follows: Total = .96; Understanding of the Self and Client = .93; and Personal Security = .95.

Procedure

Based upon preliminary power analyses a minimum of 76 dyads were recruited for study participation. The estimate for the desired sample size was calculated for a multiple regression with 3 predictor variables, a fixed alpha of .05, a fixed power of .80 and an assumed f^2 value of .15. As previously described, information regarding the specifics of the participants' demographics, educational background, and clinical and supervisory experiences was collected using a demographic questionnaire.

The participants included in this study were masters and doctoral level therapists in training and their supervisors (in other words, matched trainee-supervisor dyads). Study participants were currently enrolled in an accredited program in clinical or counseling psychology. Eligible participants were providing psychotherapy to clients on an active field placement with a caseload of at least three clients with whom they have met with for a minimum of five individual psychotherapy sessions. Participants were recruited from courses, list servs, social media, flyers, and posters. The online survey was sent out to graduate programs and training clinics nationwide.

The survey was distributed through Qualtrics, an online survey system. Participants were asked to enter name and email contact information for their supervisors who received an automated email with an anonymous link to rate trainee countertransference management. Trainee and supervisor responses were aggregated using a linked random identification number. Participation was voluntary and took approximately 20-30 minutes. Upon completion of the

online survey, participants were asked to select from three charitable causes and a small monetary donation of $1.00 was made upon their behalf.

Data Analysis Plan

Data analysis for the current study proceeded in five distinct phases. First, descriptive statistics were examined, data were screened for missing values and outliers, statistical assumptions of normality were assessed, and internal consistency reliabilities were computed for each measure. Hypothesis testing then proceeded in two phases. During phase one, correlations among measures were examined. During phase two, analyses testing for moderation, mediation, and moderated mediation were conducted.

Descriptive Statistics. Descriptive statistics were run in SPSS in order to describe participant characteristics, screen for missing data, evaluate assumptions of normality, identify potential outliers, assess for potential ceiling or floor effects, and examine the reliability of each measure.

Univariate normality was tested by calculating skewness and kurtosis values for each variable, with normality defined as an absolute skewness value < 3.0 and an absolute kurtosis value < 10.0 (Kline, 2005). Histograms and normal q-q plots of residuals were examined to evaluate assumptions of multivariate normality. Frequency distributions and boxplots were used to identify univariate outliers. Multivariate outliers were screened using indices of leverage and influence. Consistent with the guidelines proposed by Belsley, Kuh, and Welch (1980) for small to moderately sized samples, leverage values that fell above $3(k + 1)/n$ were examined further. Cook's D_i (Cook, 1977) scores were calculated as a measure of influence, with values exceeding 1.0 indicative of a potential outlier.

Hypotheses Testing.

Hypotheses 1 – 4. Hypotheses 1-4 were tested by examining the intercorrelations among variables. Specifically, the strength and direction of the following associations were examined:

- *Hypothesis 1:* The real relationship and working alliance will be significantly and positively related.
- *Hypothesis 2:* Therapist mindfulness and supervisor rating of therapist countertransference management will relate significantly and positively to therapist rating of the real relationship.
- *Hypothesis 3:* Therapist mindfulness and supervisor rating of therapist countertransference management will relate significantly and positively to therapist rating of working alliance.
- *Hypothesis 4:* Therapists' self-reported mindfulness will positively relate to supervisor ratings of therapist countertransference management.

Hypotheses 5-7. Hypotheses 5 – 7 were tested using the procedures outlined by Baron and Kenny (1986) for moderation and mediation analyses.

- *Hypothesis 5:* Meditation experience will moderate the relationship between therapist self-reported mindfulness and supervisor rating of therapist countertransference management, such that more extensive meditation experience will strengthen the relationship between therapist mindfulness and supervisor-rated countertransference management.

  Hypothesis 5 was tested using stepwise regression. First, meditation experience was dummy coded and therapist self-reported mindfulness was centered as recommended by Cohen, Cohen, West, & Aiken (2003). Next, a product term was computed by multiplying these measurements. Then, we regressed therapist

countertransference management on both predictors in Step 1 and added the interaction term (meditation experience X therapist mindfulness) in Step 2. Significant interactions were plotted to determine the nature of the interaction.

- *Hypothesis 6:* Supervisor rating of therapist countertransference management will partially mediate the relationship between therapist mindfulness and therapist rating of the real relationship.
- *Hypothesis 7:* Supervisor rating of therapist countertransference management will partially mediate the relationship between therapist mindfulness and therapist rating of the working alliance.

Hypotheses 6 and 7 were tested using PROCESS, a SPSS macro developed by Preacher, Rucker, and Hayes (2007) to test the significance of indirect effects using bootstrapping. Bootstrapping is the most appropriate method for significance testing in mediation analyses because it does not assume that the distribution of indirect effects is normal, a commonly violated assumption of the traditional Sobel test (Shrout & Bolger, 2002). We used 5,000 bootstrapped samples for each significance test. Paths were tested using the nomenclature described by Baron and Kenny (1986), where "path a" is the link from the predictor to the mediator (therapist mindfulness to therapist countertransference management), "path b" is the link from the mediator to the criterion (therapist countertransference management to the working alliance [Hypothesis 7] or the real relationship [Hypothesis 6]), and "path c" is the direct link from the predictor to the criterion without accounting for the mediator. The upper and lower values of the 95% confidence interval around each indirect effect were examined to

determine significance. If the upper and lower values of the 95% confidence interval around the indirect effects did not include zero, evidence for the indirect (mediating) effect was demonstrated.

Hypotheses 8a and 8b. Hypotheses 8a and 8b were tested using multiple linear regression; analyses were conducted with bootstrapped samples using the PROCESS Macro in SPSS. Prior to analysis all continuous variables were centered to reduce multicollinearity.

- *Hypothesis 8a:* Results will support evidence of moderated mediation as depicted in Figure 1. Specifically, supervisor rating of therapist countertransference management will mediate the positive relationship between therapist mindfulness and the real relationship and therapist meditation experience will moderate this mediated relationship, such that therapist meditation experience will strengthen the positive relationship between therapist mindfulness and the real relationship.
- *Hypothesis 8b:* Results will support evidence of moderated mediation as depicted in Figure 2. Specifically, supervisor rating of therapist countertransference management will mediate the positive relationship between therapist mindfulness and the working alliance and therapist meditation experience will moderate this mediated relationship, such that therapist meditation experience will strengthen the positive relationship between therapist mindfulness and the working alliance.

Hypotheses 8a and 8b examined the conditional indirect effects of mindfulness on the real relationship (Hypothesis 8a) and the working alliance (Hypothesis 8b), as moderated by therapist meditation experience. These hypotheses were tested with moderated mediation using the SPSS macro PROCESS using 5,000 bootstrapped samples for each significance test.

Chapter IV: Results

Data Cleaning and Analysis of Missing Data

Upon examining the dataset, there were a few missing items on individual subscales. Specifically, there were six missing item scores from therapist ratings on the FFMQ and two missing item scores from supervisor ratings on the CMS. For Client One, there were four missing item scores for therapist ratings on the RRI-T. On the WAI-SR, there were no missing items. For Client Two, there was only one missing item score from the RRI-T. For Client Three, there was only one missing item score from the WAI-SR. Missing individual items were replaced with the mean score of the non-missing items. In addition, two therapists did not provide ratings on the RRI-T and WAI-SR for Clients Two and Three and one therapist did not provide ratings for Client Three. These missing data were left as missing and mean scores for the RRI-T and WAI-SR were computed based upon the therapists' non-missing ratings for Clients One and Two.

Assumptions of univariate normality were met such that absolute values of skewness and kurtosis for all the measures in the study are within the acceptable range of < 3 and < 10 respectively (Kline, 2005). Visual inspection of histograms and QQ plots revealed that one score (Case 62) on the CMS Total scale was more than 4 standard deviations below the mean and as an extreme value, did not fall within the normal multivariate distribution. Examination of frequency distributions and boxplots also identified Case 62 on the CMS Total scale as a univariate outlier. As such, this case was excluded from further analysis. No multivariate outliers were identified, such that Cook's D_i (Cook, 1977) scores did not exceed a value of 1.0. Descriptive statistics for each of the measures and their subscales are presented in Table 1.

Table 4.1

Descriptive Statistics

	N	Range	Minimum	Maximum	Mean	*SD*	Skew	Kurtosis
FFMQ Total	76	86.00	85.00	171.00	138.74	16.51	-.57	.83
FFMQ Observe	76	24.00	13.00	37.00	27.69	4.68	-.51	.36
FFMQ Describe	76	22.00	18.00	40.00	31.25	4.77	-.36	.15
FFMQ Act/Aware	76	20.00	17.00	37.00	27.28	4.51	-.11	-.31
FFMQ Non-judge	76	32.00	8.00	40.00	29.34	6.79	-.84	.88
FFMQ Non-react	76	16.00	15.00	31.00	23.07	3.67	-.24	-.51
RRI-T Total	76	19.67	37.67	57.33	47.96	4.51	.01	-.50
RRI-T Genuine	76	11.67	17.33	29.00	23.80	2.41	.12	-.04
RRI-T Realism	76	11.00	18.00	29.00	24.16	2.42	-.10	-.58
WAI-SR Total	76	20.00	40.00	60.00	50.62	4.85	-.02	-.72
WAI-SR Goals	76	7.67	12.33	20.00	16.88	1.98	-.18	-.86
WAI-SR Tasks	76	8.67	11.33	20.00	16.14	2.00	-.05	-.71
WAI-SR Bond	76	6.67	13.33	20.00	17.61	1.60	-.27	-.72
CMS Total	76	48.00	57.00	105.00	86.90	10.58	-.56	.22
CMS USC	76	24.00	31.00	55.00	44.63	5.37	-.45	.03
CMS PS	76	24.00	26.00	50.00	42.27	5.92	-.53	.01

Note. FFMQ Total, Observe, Describe, Act/Aware, Non-judge, and Non-react refer to Five Factor Mindfulness Questionnaire total and subscales; RRI-T Total, Genuine, and Realism refer to Real Relationship Inventory-Therapist Form total and subscales; WAI-SR Total, Goals, Tasks, and Bond refers to Working Alliance Short Form Revised total and subscales; CMS Total, USC, and PS refer to the Countertransference Management Scale total, Understanding of the Self and Client, and Personal Security subscales.

Scale and Subscale Reliability

Five Factor Mindfulness Questionnaire (FFMQ; Baer et al., 2006*).* In the current study, the FFMQ and its subscales had good to excellent internal consistency reliability with alpha coefficients as follows: FFMQ Total = .92; Observe subscale = .79; Describe subscale = .88; Act with Awareness subscale = .84; Non-judge subscale = .95; Non-reactive subscale = .82.

Real Relationship Inventory-Therapist Form (RRI-T; Gelso et al., 2005). In the current study, the RRI-T was shortened to two six-item subscales in order to reduce participant burden. The shortened RRI-T total scale and subscales demonstrated good internal consistency reliability. Total scale internal consistency reliability coefficients across the three client ratings ranged from .81 to .91; alphas for the Genuineness subscale ranged from .72 to .81; and alphas for the Realism subscale ranged from .70 to .87. When items were averaged across all three clients, internal reliability estimates were as follows: Total = .88; Genuineness = .79; Realism = .80.

Working Alliance Inventory-Short Revised (WAI-SR; Hatcher & Gillaspy, 2006). In the current study, internal consistency reliability estimates ranged from .89 to .94 for the WAI Total scale; .84 to .93 for the Goals subscale; .79 to .89 for the WAI Tasks subscale; and .77 to .83 for the WAI Bond subscale. When items were averaged across all three clients, internal consistency reliability estimates were as follows: Total = .92; Goals = .86; Tasks = .83; Bond = .83.

Countertransference Management Scale (CMS; Perez-Rojas et al., 2017). In the current study, one item from the 11-item Understanding of the Self and Client subscale was left out from the survey in error (i.e., “Supervisee uses their theoretical understanding of clients to inform the work during the therapeutic hour”). To simulate and compare the reliability of the

full 22-item CMS to the altered 21-item CMS administered in the study tolerance analyses were run. Tolerance analyses to examine the influence of the missing CMS item on the scale's reliability were computed by calculating 21 different 20-item CMS scale scores and correlating these scores with the 21-item CMS scale. Partial 20-item composite CMS scores were highly correlated with 21-item CMS scores, with correlation coefficients ranging from .996 to .999, suggesting that even with one missing item, the 21-item CMS was still a valid and reliable measure of countertransference management. Internal consistency reliability estimates for the 21-item CMS were as follows: Total = .96; Understanding of the Self and Client = .93; and Personal Security = .95.

Hypothesis Testing

Hypotheses 1 – 4. Hypotheses 1-4 were tested by examining the strength and directionality of the intercorrelations among study variables. Intercorrelations among therapist mindfulness, countertransference management, the real relationship, and working alliance are summarized in Table 2.

Table 4.2

Correlations Among Ratings of Therapist Mindfulness, Countertransference Management, and the Real Relationship

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
FFMQ	1. Total	1														
	2. Observe	.57**	1													
	3. Describe	.55**	.13	1												
	4. Act/Aware	.65**	.27*	.18	1											
	5. Non-judge	.78**	.26*	.19	.37**	1										
	6. Non-react	.82**	.30**	.46**	.47**	.62**	1									
CMS	7. Total	.23*	-.11	.38**	.02	.22*	.26*	1								
	8. USC	.22*	-.08	.36**	-.001	.19*	.21*	.93**	1							
	9. PS	.23*	-.12	.35**	.04	.22*	.28**	.94**	.76**	1						
RRI-T	10. Total	.20*	.14	.18	-.04	.12	.32**	.22*	.20*	.21*	1					
	11. Genuine	.21*	.10	.19*	-.003	.13	.33**	.20*	.16	.21*	.94**	1				
	12. Realism	.17	.16	.15	-.07	.09	.28**	.21*	.21*	.18	.94**	.75**	1			
WAI-SR	13. Total	.22*	.12	.23*	.15	.02	.31**	.18	.10	.22*	.68**	.67*	.60**	1		
	14. Goals	.14	.12	.22*	.05	-.05	.21*	.08	-.01	.15	.63**	.64**	.53**	.92**	1	
	15. Task	.21*	.12	.24*	.19*	-.01	.27**	.08	.04	.11	.48**	.45**	.45**	.86**	.69**	1
	16. Bond	.24*	.08	.13	.16	.15	.33**	.33**	.27**	.35**	.68**	.67**	.60**	.82**	.69**	.51**

Note. ** $p < .01$ level of significance, * $p < .05$ level of significance (1-tailed). FFMQ Total, Observe, Describe, Act/Aware, Non-judge, and Non-react refer to Five Factor Mindfulness Questionnaire total and subscales; CMS Total, USC, and PS refer to the Countertransference Management Scale total, Understanding of the Self and Client, and Personal Security subscales; RRI-T Total, Genuine, and Realism refer to Real Relationship Inventory-Therapist Form total and subscales; WAI-SR Total, Goals, Tasks, and Bond refers to Working Alliance Short Form Revised total and subscales.

Hypothesis 1: Therapist rating of the real relationship and working alliance will be significantly and positively related. As hypothesized, therapist ratings of the real relationship and working alliance were significantly correlated and demonstrated a large positive relationship to one another ($r = .68$, $p < .001$).

Hypothesis 2: Therapist mindfulness and supervisor rating of therapist countertransference management will relate significantly and positively to therapist rating of the real relationship. As hypothesized, therapist self-reported mindfulness was positively and significantly correlated with therapist ratings of the real relationship ($r = .20$, $p = .04$). The strength of the correlation between therapist self-reported mindfulness and therapist ratings of the real relationship was small to moderate. Likewise, supervisor ratings of countertransference management were positively and significantly correlated with therapist ratings of the real relationships ($r = .22$, $p = .03$). The strength of the relationship between supervisor ratings of countertransference management and therapist ratings of the real relationship was small to moderate.

Hypothesis 3: Therapist mindfulness and supervisor rating of therapist countertransference management will relate significantly and positively to therapist rating of working alliance. As hypothesized, therapist self-reported mindfulness was significantly and positively correlated with therapist ratings of the working alliance ($r = .22$, $p = .03$). The strength of the correlation between therapist self-reported mindfulness and therapist ratings of the working alliance was small to moderate. Contrary to expectations, the small positive relationship between supervisor ratings of countertransference management and therapist ratings of the working alliance trended in the hypothesized direction but did not reach significance ($r = .18$, $p = .07$). Further examination of the correlations between total scale and subscales scores

on the CMS and WAI-SR showed that supervisor ratings of the therapists' personal security and therapist ratings of the working alliance were significantly correlated and demonstrated a small to moderate positive relationship with one another (r = .22, p = .03). Additionally, therapist ratings of the working bond were positively and significantly correlated with supervisor ratings of countertransference management (r = .33, p = .002), understanding of the self and client (r = .27, p = .01), and personal security of the therapist (r = .35, p = .001). The strength of these correlations suggested a moderate relationship between therapist ratings of the working bond and supervisor ratings of countertransference management. In combination, partial support for the research hypothesis was found.

Hypothesis 4: Therapists' self-reported mindfulness will positively relate to supervisor ratings of therapist countertransference management. As hypothesized, the correlation between therapist self-reported mindfulness and supervisor ratings of countertransference management was positive and significant (r = .23, p = .02). The strength of the relationship between therapist self-reported mindfulness and supervisor ratings of countertransference management was small to moderate.

Hypotheses 5-7. Hypotheses 5 – 7 were tested using the procedures outlined by Baron and Kenny (1986) for moderation and mediation analyses. Prior to analysis, all continuous variables were centered to reduce multicollinearity. Mediation analyses were examined using the PROCESS macro to test the significance of indirect effects; 5,000 bootstrapped samples were used for each significance test. For moderation analyses, meditation experience was dummy coded as a dichotomous variable. Therapists in training who indicated that they did not practice mindfulness meditation were coded as non-meditators (n = 28, 36.8%). Therapists in training

who indicated that they sometimes or regularly practiced mindfulness meditation were coded as meditators (n = 48, 63.2%).

Hypothesis 5: Meditation experience will moderate the relationship between therapist self-reported mindfulness and supervisor rating of therapist countertransference management, such that more extensive meditation experience will strengthen the relationship between therapist mindfulness and supervisor-rated countertransference management. Meditation experience was examined as a moderator of the relationship between therapist self-reported mindfulness and supervisor rating of countertransference management using stepwise multiple regression analyses. Dummy coded values for meditation experience (no meditation experience = 0, meditation experience =1) and FFMQ Total scale scores were entered in the first step of the regression analysis. In the second step of the regression analysis, the interaction term between meditation experience and FFMQ Total scores was entered. The regression model was significant, $F(3, 72) = 3.90$, $p = .01$, accounting for 14 percent of the variance in supervisor rated countertransference management. The moderating effect of meditation experience was significant and demonstrated large effects on the relationship between therapist self-reported mindfulness and countertransference management, $b = .36$, $t(72) = 2.32$, $p = .02$. Regression results are summarized in Table 3. To determine the direction of the moderator, the interaction effect was plotted at two levels: meditators versus non-meditators (see Figure 3 below). As hypothesized, meditation experience strengthened the relationship between therapist self-reported mindfulness and supervisor-rated countertransference management.

Table 4.3

Results of Moderated Multiple Regression Analyses of Therapist Mindfulness and Meditation Experience on Countertransference Management

	Variable	B	S.E.	β	t	Sig.	95% Confidence Interval	
							Lower Bound	Upper Bound
Step 1	Constant	88.98	2.00		44.60	.00	85.01	92.96
	FFMQ Total	.18	.08	.27	2.34	.02	.03	.32
	Meditation Exp.	-3.27	2.54	-.15	-1.29	.20	-8.33	1.79
Step 2	Constant	87.61	2.02		43.23	.00	83.57	91.65
	FFMQ Total	-.07	.13	-.11	-.54	.59	-.32	.19
	Meditation Exp.	-2.26	2.51	-.10	-.90	.37	-7.25	2.74
	FFMQxMeditation	.36	.16	.45	2.32	.02	.05	.67

Note. FFMQ Total refers to the Five Factor Mindfulness Questionnaire Total Scale; Meditation Exp. refers to meditators versus non-meditators; FFMQxMeditation refers to the interaction between therapist self-reported mindfulness and meditation experience.

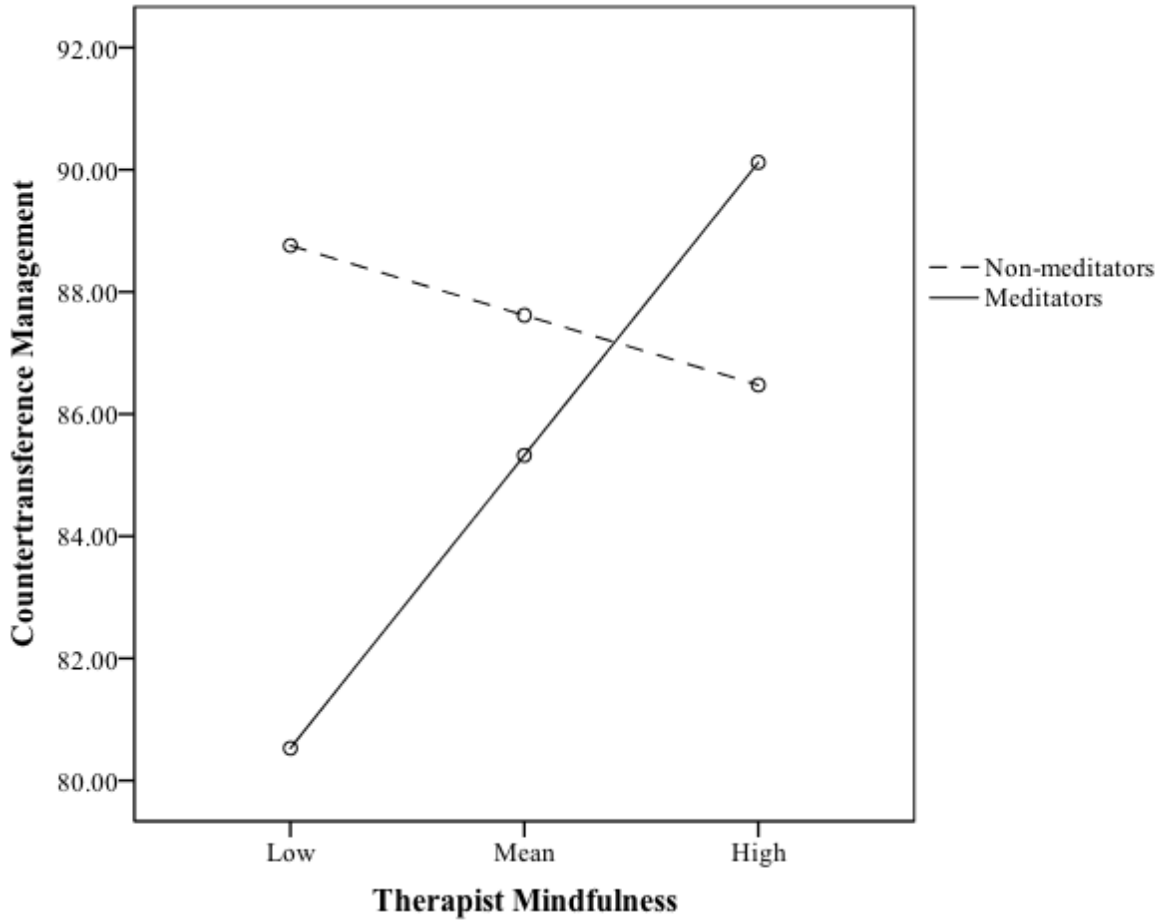

Figure 4.1. The interaction of self-reported therapist mindfulness and meditation experience on countertransference management as rated by supervisors (Hypothesis 5).

Hypothesis 6: Supervisor rating of therapist countertransference management will partially mediate the relationship between therapist mindfulness and therapist rating of the real relationship. Contrary to hypotheses, no evidence for the mediating effects of countertransference management on the relationship between therapist mindfulness and the real relationship was found. Regression paths are summarized in Table 4.

Table 4.4

Mediation Effects of Countertransference Management on the Relationship between Therapist Mindfulness and the Real Relationship

Regression path	B	*t*	*p*	95% Confidence Interval	
				Lower Bound	Upper Bound
Path a (FFMQ on CMS)	.15	2.07	.04	.01	.29
Path b (CMS on RRI-T)	.08	1.57	.12	-.02	.18
Path c (FFMQ on RRI-T)	.06	1.77	.08	-.01	.12
Direct effect (FFMQ on RRI-T)	.04	1.37	.18	-.02	.11
Indirect effect (FFMQ on RRI-T)	.01			-.005	.03

Note. FFMQ refers to the Five Factor Mindfulness Questionnaire total score; CMS refers to the Countertransference Management Scale total score; RRI-T refers to the Real Relationship Inventory Therapist Form total score.

Hypothesis 7: Supervisor rating of therapist countertransference management will partially mediate the relationship between therapist mindfulness and therapist rating of the working alliance. Contrary to hypotheses, no evidence of countertransference management as a mediator in the relationship between therapist mindfulness and the working alliance was found. Regression paths are summarized in Table 5.

Table 4.5

Mediation Effects of Countertransference Management on the Relationship between Therapist Mindfulness and the Working Alliance

Regression path	B	*t*	*p*	95% Confidence Interval	
				Lower Bound	Upper Bound
Path a (FFMQ on CMS)	.15	2.07	.04	.01	.29
Path b (CMS on WAI-SR)	.06	1.12	.26	-.05	.17
Path c (FFMQ on WAI-SR)	.06	1.95	.06	-.001	.13

Direct effect (FFMQ on WAI-SR)	.06	1.64	.11	-.01	.12
Indirect effect (FFMQ on WAI-SR)	.01			-.01	.03

Note. FFMQ refers to the Five Factor Mindfulness Questionnaire total score; CMS refers to the Countertransference Management Scale total score; WAI-SR refers to the Working Alliance Inventory Short Form Revised total score.

Hypotheses 8a and 8b. Hypotheses 8a and 8b concerned the conditional indirect effects of therapist mindfulness on therapist rating of the real relationship and working alliance, respectively, as moderated by therapist meditation experience. These hypotheses were tested using the SPSS PROCESS macro using 5,000 bootstrapped samples for each significance test. Prior to analysis, all continuous variables were centered to reduce multicollinearity. Meditation experience was dummy coded as a dichotomous variable. Therapists in training who indicated that they did not practice mindfulness meditation were coded as non-meditators (n = 28, 36.8%). Therapists in training who indicated that they regularly practiced mindfulness meditation or sometimes practiced mindfulness meditation were coded as meditators (n = 48, 63.2%).

Hypothesis 8a: Supervisor rating of therapist countertransference management will mediate the positive relationship between therapist mindfulness and the real relationship and therapist meditation experience will moderate this mediated relationship, such that therapist meditation experience will strengthen the positive relationship between therapist mindfulness and the real relationship. Contrary to theorized expectations, the indirect effect of therapist mindfulness on therapist rating of the real relationship as moderated by therapist meditation experience was not statistically significant for non-meditators (b = -.01 [-.04, .01]) or meditators (b = .02 [-.01, .06]). As such, hypothesis 8a was not supported.

Hypothesis 8b: Supervisor rating of therapist countertransference management will mediate the positive relationship between therapist mindfulness and the working alliance and

therapist meditation experience will moderate this mediated relationship, such that therapist meditation experience will strengthen the positive relationship between therapist mindfulness and the working alliance. Contrary to theorized expectations, the indirect effect of therapist mindfulness on therapist rating of the working alliance as moderated by therapist meditation experience was not statistically significant for non-meditators (b = -.004 [-.04, .01]) or meditators (b = .02 [-.02, .07]). As such, hypothesis 8b was not supported.

Exploratory Findings. Exploratory analyses examining the moderating effects of meditation experience on the relationship between therapist mindfulness and the real relationship and on the relationship between therapist mindfulness and the working alliance were tested using the procedures outlined by Baron and Kenny (1986) for moderation analyses. As previously described, all continuous variables were centered to reduce multicollinearity and meditation experience was dummy coded as a dichotomous variable. Therapists in training who indicated that they did not practice mindfulness meditation were coded as non-meditators (n = 28, 36.8%). Therapists in training who indicated that they sometimes or regularly practiced mindfulness meditation were coded as meditators (n = 48, 63.2%).

Meditation experience as a moderator of the relationship between therapist mindfulness and the real relationship. Exploratory analyses demonstrated that meditation experience moderated the positive relationship between therapist self-reported mindfulness and therapist ratings of the real relationship ($F(3, 72) = 3.04$, p = .03) and accounted for 11.2 percent of the variance in therapist ratings of the real relationship. Stepwise regression results are summarized in Table 6. The interaction between therapist mindfulness and meditation experience was significant and demonstrated a moderate effect (b = .16, $t(72) = 2.36$, p = .02),

such that meditation experience strengthened the positive relationship between therapist mindfulness and the real relationship (see Figure 4 below).

Table 4.6

Results of Moderated Multiple Regression Analyses of Therapist Mindfulness and Meditation Experience on the Real Relationship

	Variable	B	S.E.	β	t	Sig.	95% Confidence Interval	
							Lower Bound	Upper Bound
Step 1	Constant	40.11	4.39		9.14	.00	31.37	48.85
	FFMQ Total	.06	.03	.22	1.83	.07	-.01	.12
	Meditation Exp.	-.56	1.10	-.06	-.51	.61	-2.75	1.63
Step 2	Constant	54.39	7.41		7.35	.00	39.63	69.15
	FFMQ Total	-.05	.06	-.18	-.87	.39	-.16	.06
	Meditation Exp.	-.12	1.08	-.01	-.11	.92	-2.28	2.05
	FFMQxMeditation	.16	.07	.46	2.36	.02	.02	.29

Note. FFMQ Total refers to the Five Factor Mindfulness Questionnaire Total Scale; Meditation Exp. refers to meditators versus non-meditators; FFMQxMeditation refers to the interaction between therapist self-reported mindfulness and meditation experience.

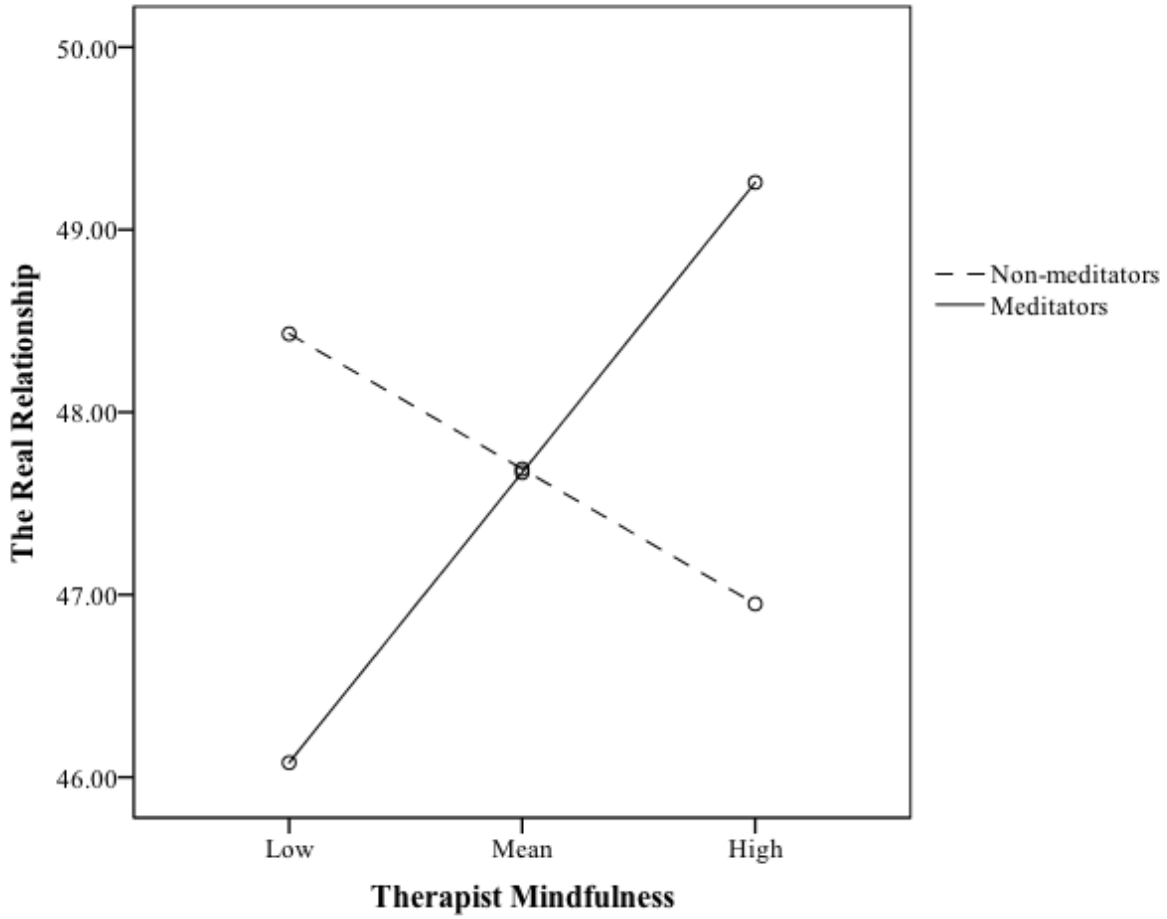

Figure 4.2. The interaction of self-reported therapist mindfulness and meditation experience on therapist ratings of the real relationship.

Meditation experience as a moderator of the relationship between therapist mindfulness and the working alliance. Likewise, exploratory analyses also demonstrated that meditation experience moderated the positive relationship between therapist self-reported mindfulness and therapist ratings of the working alliance ($F(3, 72) = 3.40$, $p = .02$) and accounted for 12.4 percent of the variance in therapist ratings of the working alliance. Stepwise regression results are summarized in Table 7. The interaction between therapist mindfulness and meditation experience was significant and demonstrated moderate effects ($b = .18$, $t(72) = 2.48$,

p = .02), such that meditation experience strengthened the positive relationship between therapist mindfulness and the working alliance (see Figure 5 below).

Table 4.7

Results of Moderated Multiple Regression Analyses of Therapist Mindfulness and Meditation Experience on the Working Alliance

	Variable	B	S.E.	β	t	Sig.	95% Confidence Interval	
							Lower Bound	Upper Bound
Step 1	Constant	41.58	4.70		8.84	.00	32.20	50.95
	FFMQ Total	.07	.04	.22	1.90	.06	-.003	.14
	Meditation Exp.	-.13	1.18	-.01	-.11	.92	-2.48	2.23
Step 2	Constant	57.68	7.91		7.29	.00	41.91	73.44
	FFMQ Total	-.06	.06	-.19	-.93	.35	-.17	.06
	Meditation Exp.	.38	1.16	.04	.33	.75	-1.93	2.68
	FFMQxMeditation	.18	.07	.49	2.49	.02	.04	.32

Note. FFMQ Total refers to the Five Factor Mindfulness Questionnaire Total Scale; Meditation Exp. refers to meditators versus non-meditators; FFMQxMeditation refers to the interaction between therapist self-reported mindfulness and meditation experience.

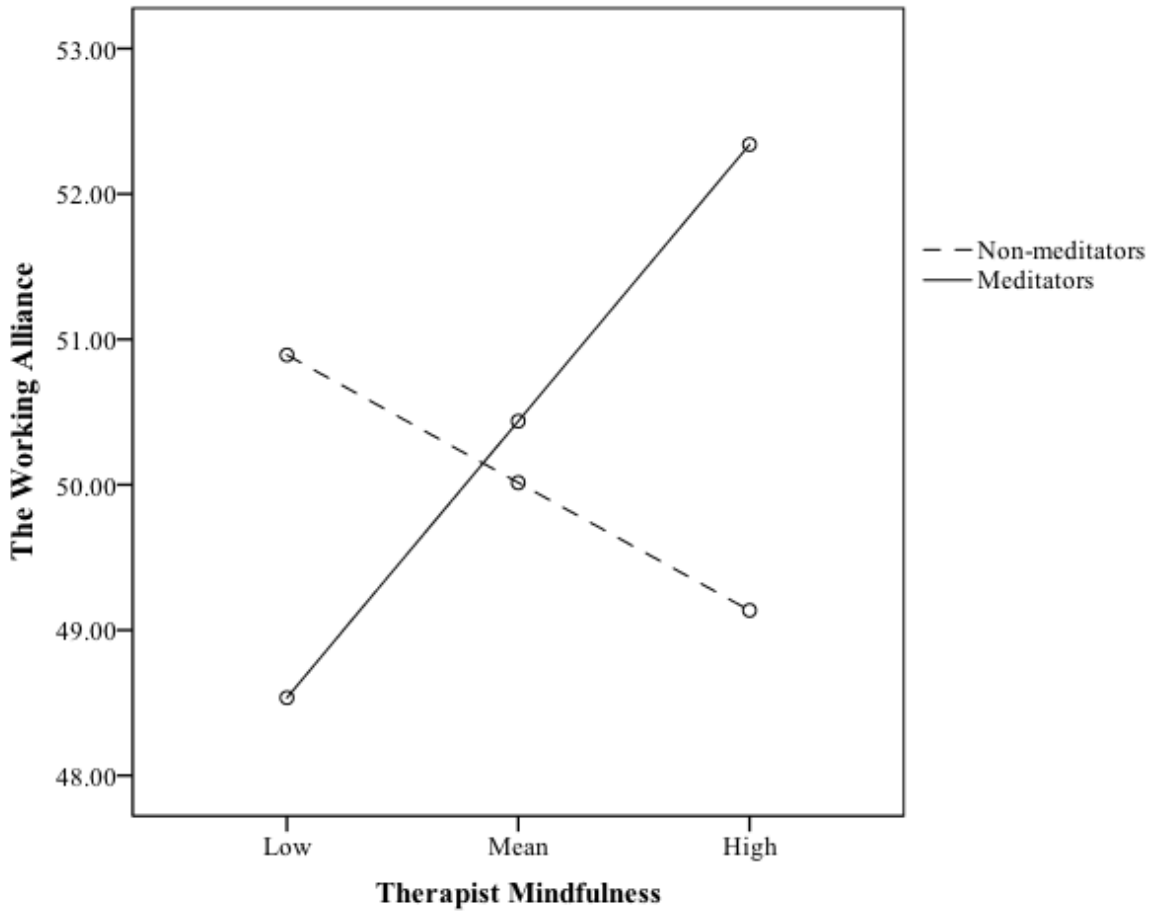

Figure 4.3. The interaction of self-reported therapist mindfulness and meditation experience on therapist ratings of the working alliance.

Chapter V: Discussion

The purpose of this study was to test the theorized connections among therapist mindfulness, meditation experience, countertransference management, the working alliance, and the real relationship between therapist and client. This chapter discusses study results within the context of previous research. Study limitations and directions for future research are summarized. Finally, implications of study findings for theory, practice, training, and supervision are presented.

Summary of Findings

Consistent with the tripartite model of the therapeutic relationship (Carter & Gelso, 1985, 1994), mindfulness theory (Bruce et al., 2010; Siegel, 2007), and the existing body of empirical research (e.g., Fatter & Hayes, 2013; Gelso, 2014; Gelso et al., 2018; Hayes et al., 2018; Ryan et al., 2012), results largely supported the hypothesized relationships among therapist mindfulness, countertransference management, the real relationship, and the working alliance. Consistent with Hypothesis 1, the correlation between therapist ratings of the real relationship and working alliance was positive and significant. As expected and consistent with Hypothesis 2, therapist self-reported mindfulness and supervisor ratings of countertransference management related positively and significantly to therapist ratings of the real relationship. There was also partial support for Hypothesis 3; results demonstrated that therapist self-reported mindfulness positively and significantly related to therapist ratings of the working alliance, but the positive relationship between supervisor ratings of countertransference management and therapist ratings of the working alliance did not reach significance. Finally, therapist self-reported mindfulness was positively and significantly correlated with countertransference management, as expected and consistent with Hypothesis 4.

In the current sample, correlations between therapist ratings of the real relationship and working alliance were in line with effect sizes reported in the wider body of literature. The large relationship between therapist ratings of the real relationship and working alliance (r = .68) is similar to effect sizes (ranging from .50 to .69) reported in studies investigating the real relationship and working alliance as predictors of session and treatment outcomes (Bhatia & Gelso, 2017; Fuertes et al., 2007; Gelso et al., 2005; Lo Coco et al., 2011; Marmarosh et al., 2009). Likewise, the small to moderate positive relationship between therapist self-reported mindfulness and supervisor rated countertransference management (r = .23) was similar to the effect size of .21 reported by the Fatter and Hayes (2013) study of the relationship between therapist mindfulness and countertransference management.

In contrast, the small to moderate correlations between therapist self-reported mindfulness and therapist ratings of the real relationship (r = .20) and working alliance (r = .22) were smaller than the moderate to large correlation between therapist self-reported mindfulness and therapist ratings of the working alliance (r = .45) reported by Ryan et al. (2012). Discrepancies in the magnitude of these relationships may partially be explained by the current study's use of an averaged rating of the real relationship and working alliance across three therapy clients, instead of a single therapy client. Thus, by better accounting for potential client effects on the real relationship and working alliance, results from this study may more closely reflect the true relationship between therapist mindfulness and the therapeutic relationship.

To our knowledge no other study has directly examined the relationship between countertransference management and the strength of the therapeutic relationship. In the current study, small to moderate relationships were found between supervisor ratings of countertransference management and therapist ratings of the real relationship (r = .22) and the

working alliance (r = .18). As previously discussed, the correlation between supervisor ratings of countertransference management and therapist ratings of the real relationship reached significance while the correlation between supervisor ratings of countertransference management and therapist ratings of the working alliance did not. Given the relatively small size of the sample, it seems possible that a significant correlation between supervisor ratings of countertransference management and therapist ratings of working alliance may have been detected in a larger sample with more power to detect small to medium effect sizes.

Exploration of subscale correlations yielded additional insights into the theoretical and empirical connections among study variables. Notably, supervisor ratings of countertransference management were positively and significantly correlated with therapist ratings of the working bond between therapist and client but not with the working tasks or goals of therapy. Further, the strength of the correlation suggested a large positive relationship between supervisor ratings of countertransference management and therapist ratings of the working bond (r = .33). Coupled with evidence of the positive association between countertransference management and the real relationship, this finding seems to correspond with and support the theoretical assertion that countertransference management is essential to facilitating a strong real relationship between client and therapist, which in turn serves as the basis of the working alliance (Carter & Gelso, 1985, 1994; Gelso, 2011, 2014).

With respect to various facets of therapist self-reported mindfulness, there was a positive and significant correlation between the ability to describe and label one's experience with countertransference management (r = .38), genuineness (r = .19), and the working tasks (r = .24) and goals (r = .22) of therapy. Consistent with findings from Fatter and Hayes (2013) that demonstrated that therapists' self-reported non-reactivity was positively correlated with

countertransference management as measured by supervisor ratings on the CFI (r = .32), therapists' self-reported non-reactivity to their inner experience was positively and significantly related to countertransference management as measured by supervisor ratings on the CMS (r = .26). Further extending these findings, study results showed that therapists' self-reported non-reactivity was also positively and significantly correlated with therapist ratings of the real relationship (r = .32) and working alliance (r = .31). These correlations demonstrate moderate to large effects and fit with the practical notion that the ability to genuinely and non-reactively communicate one's thoughts and feelings in the face of difficult client material is essential to effective therapeutic relating and advancing the work of therapy (Fatter & Hayes, 2013).

Study findings also found support for the moderating effects of meditation experience, consistent with Hypotheses 5. In particular, results suggest that therapist meditation experience strengthened the positive relationships between therapist self-reported mindfulness and supervisor ratings of countertransference management. With respect to countertransference management, findings that meditation experience strengthened the positive relationship between therapist self-reported mindfulness and supervisor ratings of countertransference management extend prior knowledge. Specifically, in their 2013 study of therapist self-reported mindfulness, meditation experience, self-differentiation, and supervisor rated countertransference management, Fatter and Hayes (2013) demonstrated that years of meditation experience was the only unique predictor of supervisor ratings of countertransference management.

Likewise, exploratory findings revealed that meditation experience strengthened the positive relationships between therapist self-reported mindfulness and therapist ratings of real relationship and therapist self-reported mindfulness and therapist ratings of the working alliance.

With respect to the real relationship, this is the first known study to examine the moderating role of meditation experience on this relationship. Evidence that meditation experience strengthens the relationship between therapist mindfulness and the real relationship represents an important advance in our empirical understanding of the theorized connections among therapist mindfulness, meditation, and effective therapeutic relating. With respect to the working alliance, findings that meditation experience strengthened the positive relationships between therapist self-report mindfulness and therapist ratings of the working alliance are consistent with, and build upon, existing empirical evidence linking therapist self-reported mindfulness with the strength of the working alliance as rated by both therapists and clients (Ryan et al., 2012). In combination, these results support theoretical conceptualizations of mindfulness as intra- and interpersonal attunement (Bruce et al., 2010; Siegel, 2007a) and provide preliminary empirical support for the use of mindfulness meditation as a means to enhance countertransference management and relate more effectively with one's clients.

Additionally, the moderating effects of meditation experience on the respective relationships between therapist mindfulness and supervisor ratings of countertransference management, therapist ratings of the real relationship, and therapist ratings of the working alliance also offer some additional support for the FFMQ as a valid measure of dispositional mindfulness in meditating samples. These results are consistent with prior findings suggesting that meditation experience influences one's response to the FFMQ (Baer et al., 2006; Baer et al., 2008; Rau et al., 2016; Van Dam, Earleywine, & Danoff-Burg, 2009) and strengthens the associations between FFMQ total and subscale scores and other measures of psychological well-being (Baer et al., 2006). Presumably, therapists in training with prior meditation experience and in turn, more knowledge of mindfulness as a trait, state, and process may be better able to

respond to FFMQ items as intended, thus yielding more valid and reliable ratings of self-reported dispositional mindfulness. As such, stronger associations between therapist self-reported mindfulness and measures of supervisor ratings of countertransference management, therapist ratings of the real relationship, and therapist ratings of the working alliance among meditating versus non-meditating therapists in training may in part be explained by these measurement effects.

Contrary Hypotheses 6 and 7, findings did not support supervisor rated countertransference management as a mediator of the relationship between therapist self-reported mindfulness and therapist ratings of the real relationship or the working alliance. Likewise, no evidence for the proposed model of moderated mediation of therapist mindfulness, meditation experience, and countertransference management on the real relationship or working alliance as predicted by Hypotheses 8a and 8b was demonstrated by these data. These findings contradict conceptualizations that therapist mindfulness indirectly influences the real relationship and the working alliance via enhanced countertransference management (Hayes et al. 2018). In evaluating and making sense of these unexpected results, it is important to consider the potential influence of study methods and measurement effects.

Failure to find evidence of mediation and moderated mediation may in part be explained by limitations inherent to the measures used in the study. Notably, meta-analytic findings suggest that the relationships among countertransference management, countertransference behavior, and treatment outcomes are weaker when ratings are provided by therapists in training (Hayes et al., 2011). Depending on prior meditation experience and clinical training, therapists in training may vary widely in their ability to reliably estimate trait mindfulness and rate the strength and quality of the real relationship and working alliance, thus weakening the observed

relationships among study variables. Similarly, in the absence of a measure of countertransference, supervisor ratings of countertransference management may have limited validity. That is, if there is not a countertransference reaction in response to the clients rated by the therapists in training, supervisor would not have had an opportunity to observe countertransference management. Future research efforts to replicate and extend mediation models might consider limiting the sample based upon meditation experience and educational status and including both self and other ratings of therapist mindfulness, the real relationship, the working alliance, and countertransference reactions/behavior.

Additionally, prior research findings indicate that subscales on the FFMQ are not strongly intercorrelated and may vary in their discriminant validity (Baer et al., 2006). Accordingly, using the total FFMQ score as the predictor variable may have weakened the associations among variables included in the models of mediation and it may be fruitful to examine individual facets of dispositional mindfulness as predictor variables instead of using total FFMQ scores. To this end, study findings demonstrating strong correlations among the Describe and Non-reactive subscales, countertransference management, and aspects of the real relationship and working bond suggest that these exploring these individual facets of mindfulness as predictor variables might be promising directions for future research. Finally, given the statistical power necessary to detect small effects, it seems plausible that examining these relationships within a larger sample of therapists in training could also yield different results. In sum, studies replicating and extending the current study using various measures and larger samples is needed.

Study Limitations

There are several limitations to the study that must be considered when interpreting the results. First and foremost, the study design is correlational in nature and thus cannot establish causal relationships among the predictor and criterion variables. Study results offer insights into the theorized associations among therapist mindfulness, countertransference management, the real relationship, and the working alliance but cannot determine whether therapist mindfulness causes changes in supervisor ratings of countertransference management or therapist ratings of the real relationship and working alliance. To establish causality, longitudinal research is needed.

Furthermore, there are considerations that may impact the study's external validity and generalizability. The study's target population was therapists in training from accredited graduate programs in clinical or counseling psychology and their clinical supervisors. Study participants were primarily recruited by emailing training directors and asking them to forward an invitation to participate to enrolled graduate students. It is unknown how many training directors actually forwarded the request to students and whether they or the programs they represented differed in a meaningful way from those who did not. It also is possible that the therapists in training who elected to participant in the study were already interested and personally invested in mindfulness-based meditation practices.

As well, because participation required that therapists in training agreed to be evaluated by their supervisors, it seems likely that self-selection bias may be present. Therapists in training who did not want to be evaluated by their supervisors and supervisors who did not want to rate their supervisees may have chosen not to participate. Indeed, it seems likely that therapists in training who feel less close to their supervisors would have elected not to participate in this study given that doing so meant that their supervisor would be evaluating their work as a therapist.

Similarly, supervisors who were unfamiliar with their supervisee's clinical work, did not feel comfortable evaluating their supervisee's skill as a therapist, or were less invested in the supervisee's development may have declined to participate. Thus, the hierarchical and evaluative nature of the supervisory relationship may have influenced study participation for both therapists in training and supervisors. Although speculative, the potential for such selection biases raise questions about external validity and the generalizability of the study's findings to the broader population of therapists in training.

The use of self-report measures in the study presents additional limitations. Therapists in training provided self-reports of their meditation experience, mindfulness practice, perceptions of the real relationships with their clients, and perceptions of working alliances with their clients. As such, these measures are vulnerable to response bias (Heppner, Wampold, & Kivlighan, 2008). As Heppner et al. (2008) noted, participants may guess the purpose of the study and respond in a manner they believe will confirm the researcher's hypothesis. Similarly, participants may consciously or unconsciously attempt to avoid cognitive dissonance between their idealized standards and actual behavior and respond in a socially desirable manner. On the other hand, participants may have limited insight into the constructs being measured and be unable to reliably report on their personal traits and experiences.

Indeed, existing empirical research suggests that therapists in training are limited in their ability to accurately and reliably estimate their therapy skills (Hill et al., 2007; Howard et al., 2006) and that these self-report biases may weaken observed relationships among therapists effects and treatment outcomes (Hayes et al., 2011). Further, the ability to reliably evaluate and report dispositional mindfulness and strength of the therapeutic relationship may vary as a function clinical training and experience. In this respect, including both masters and doctoral

level students with widely varying levels of clinical experience (and potential exposure to mindfulness-based practices) in the current study presents a significant confound when interpreting study findings. Future research efforts may restrict participation based upon trainee educational status and/or include years of graduate training and clinical experience as covariates.

Given the known challenges and considerations to measuring dispositional mindfulness across meditating and non-meditating samples, it seems possible that response bias based upon meditation experience may be present in this study. As discussed in Chapter 2, research suggests that dispositional mindfulness and mindfulness cultivated through meditation are best conceptualized as two distinct constructs (Carmody et al., 2008; Rau & Williams, 2016; Thompson & Waltz, 2007). Moreover, research also has indicated that exposure to and familiarity with meditative practices can influence the ways in which participants respond to the FFMQ (Baer et al., 2008; Van Dam et al., 2009). For example, Baer et al. (2008) demonstrated that individuals without mindfulness training reported higher levels of dispositional mindfulness than those beginning a mindfulness practice. Van Dam et al. (2009) similarly found that there were systematic differences across groups in how meditators and non-meditators responded to items of the FFMQ, such that meditators reported lower mindfulness on negatively worded items (e.g., "I am easily distracted") and higher mindfulness on directly worded items (e.g., "I pay attention to sensations, such as the wind in my hair or sun on my face") than non-meditators who had similar total FFMQ scores. Accordingly, scholars have called into question the utility of the FFMQ to assess mindfulness across mediating and non-meditating samples and have recommended using other performance-based measures of mindfulness to validate self-report data (Fatter & Hayes, 2013; Garland & Gaylord, 2009). Due to cost and time constraints as well as the nature of online research, this study used the FFMQ as the sole measure of dispositional

mindfulness. As such, it is possible that therapists' in training self-reported mindfulness may have been systematically biased depending upon prior meditation experience and/or item wording. Specifically, those participants with meditation experience may be more accurate and reliable in their ratings of self-reported mindfulness than those participants without prior meditation experience.

Additionally, it is important to consider the limitations of using supervisor ratings to measure countertransference management. Beyond direct observation, a supervisor's ability to accurately rate countertransference management is largely dependent upon the quality of the supervisory relationship and therapist disclosures of countertransference (Pakdaman et al., 2015). In the current study, the length and quality of the supervisory relationship varied across dyads and it is unknown how often or how comfortable therapists in training were in disclosing countertransference reactions to their supervisors. Likewise, without a measure of countertransference reactions/behaviors observed during the therapy hour, supervisors may have limited insight into the therapist's ability to effectively manage countertransference. These potential confounds highlight questions regarding the validity of CMS scores. Future research would benefit from either controlling for or including supervisor and therapist ratings of the supervisory relationship, countertransference disclosures made in supervision, and behavioral measures of countertransference reactions and countertransference management as potential covariates.

Finally, in evaluating study findings on countertransference management relative to the larger body of prior research, it is necessary to consider possible measurement effects related to the use of the CMS as a relatively new measure and in relationship to a specific error in measurement in this study. Prior research into countertransference management almost

exclusively utilized the CFI (Hayes et al., 1991). The CMS (Perez-Rojas et al., 2017) was developed out of a similar theory of countertransference management; however, the CFI and CMS capture slightly different constructs. As such, it is possible that there will be some discrepancies in research findings across studies based upon the measure of countertransference management used. With respect to the current study, the erroneous exclusion of one of the 22 CMS scale items across all participants raises questions about the validity of the CMS scores. As described in Chapter 3, tolerance analyses suggested that this missing item had minimal effects on the reliability and validity of CMS scores, but it is a noteworthy limitation nonetheless as it represents an unintended alteration of the validated measure.

Future Research

Within the broader field of clinical psychology, considerable debate and tension exists about how psychotherapy actually works (Budge & Wampold, 2015). If we are to move the science of psychotherapy forward, additional research about the process and outcome of psychotherapy is necessary. To this end, a more complex understanding of the therapeutic relationship may shed light on the transtheoretical social and relational mechanisms of therapeutic change (Budge & Wampold, 2015; Gelso, 2014). It is essential that we examine the intra- and inter- personal factors that influence and shape the therapeutic relationship, course of treatment, and psychotherapy outcomes (Elkin, 2012). Likewise, additional research examining the influence of the supervisory relationship on the process and outcome of psychotherapy is needed (Pakdaman et al., 2015). Namely, how can therapists and supervisors alike work to effectively manage countertransference, strengthen the real relationship and working alliance, and promote client change? In the following section, specific directions for future research on the tripartite model of the therapeutic relationship, countertransference and countertransference

management, therapist mindfulness and meditation, the supervisory relationship, and diversity considerations are summarized.

The Tripartite Model of the Therapeutic Relationship. Existing research on Gelso and Carter's (1985; 1994) tripartite model of the therapeutic relationship shows strong empirical support for the model in that the real relationship, working alliance, and transference-countertransference configuration generally relate to one another and to the process and outcome of psychotherapy as predicted by theory (Gelso, 2014). However, the vast majority of the research on the tripartite model of the therapeutic relationship has been conducted by a small group of very invested researchers and may, at least to some degree, reflect researcher allegiance effects (Gelso, Kivlighan, Jr. & Markin, 2018). Additional research conducted by a larger number of researchers to replicate and extend the current literature is necessary to strengthen and further refine the tripartite model. A possible direction for future research is to conduct factor analysis to confirm whether data across samples and studies support the tripartite model (Gelso, 2014). An exploratory factor analysis conducted by Bhatia and Gelso (2013) with a sample of 249 therapists demonstrated preliminary evidence of four factors: the real relationship, the working alliance, transference, and countertransference. These findings raised questions about the proposed structure of the tripartite model as theorized and pointed to the need for further analysis using therapist, client, and external ratings (Gelso, 2014).

To date, most research on the tripartite model of the therapeutic relationship has relied heavily on the use of therapist and client ratings of the real relationship, the working alliance, and the transference-countertransference configuration. Very little use has been made of external ratings. Future research utilizing external ratings of the real relationship, the working alliance, and transference and countertransference may help to mitigate the influence of self-report bias

and social desirability. Additionally, as noted in Chapter 2, research on the therapeutic relationship often confounds therapist effects with client or dyad effects, making results difficult to interpret. Future research would do well to control for and examine these effects. Further, more sophisticated statistical analyses using actor partner interdependence models (APIM) will allow researchers to examine dyadic effects of client and therapist ratings of the real relationship, working alliance, and transference-countertransference configuration on psychotherapy process and outcome. Research on the tripartite model of the therapeutic relationship, including those using APIM, have primarily focused on time-limited, psychodynamic psychotherapy (Kivlighan et al., 2016). Additional research utilizing other models of therapy and more long-term psychotherapies would help to expand the empirical literature on the real relationship, working alliance, and transference-countertransference configuration. Information gleaned would offer valuable insights into the components of the tripartite model as transtheoretical constructs and their mutual influence on the process of psychotherapy as it unfolds across time.

Additional research on the correlates, moderators, and mediators of the real relationship, working alliance, and transference-countertransference configuration also is needed. As research efforts have primarily focused on the influence of the working alliance on psychotherapy processes and outcomes, this is particularly true for the real relationship, transference, and countertransference. Promising directions for future research include further examination of how client and therapist attachment styles relate to the real relationship, working alliance, transference, and countertransference across treatment (Gelso, 2014). Likewise, studies investigating theoretically derived moderators and mediators of the real relationship, working alliance, and transference-countertransference configuration are important to advancing the tripartite model. Gelso (2014) specifically identified the following questions for further study:

> "How do client effects interact with the real relationship to predict psychotherapy outcomes? When is negative transference helpful versus harmful to treatment? What variables mediate the differential role of the working alliance and real relationship on outcome? What therapist effects mediate or moderate the effects of countertransference on the working alliance, real relationship, and outcome of psychotherapy?" (p. 129).

Of particular relevance to training and supervision is the question of *how* therapists can work to strengthen the working alliance and real relationship. The therapist's expression of accurate empathy, personal and theoretical consistency and constancy, skillful use of intentional self-disclosure, attention to self-other boundaries, and countertransference management have been theorized as important to facilitating a strong real relationship and working alliance (Gelso et al., 2018; Gelso & Silberberg, 2016). However, little research on these therapist effects and their influence on the therapeutic relationship and psychotherapy outcomes has been completed. To our knowledge, no other study has directly examined the influence of countertransference management on the real relationship or working alliance between client and therapist. In this regard, the current study represents an important advance in our empirical understanding of psychotherapy as an intra- and inter- personal process and emphasizes the need to replicate and extend study findings using larger study samples, varied treatment modalities, and longitudinal designs.

Countertransference and Countertransference Management. The literature on countertransference and its management is both promising and limited. An updated meta-analysis conducted by Hayes et al. (2018) found that more frequent countertransference reactions were associated with poorer treatment outcomes and that better countertransference management was associated with fewer countertransference reactions and larger gains in psychotherapy

outcomes (as measured by aggregated therapist and client ratings of session depth). The authors qualified these results, noting a dearth of research directly linking countertransference and its management to distal treatment outcomes (e.g., client functioning or well-being at the end of treatment; Hayes et al., 2018). Indeed, there is only one known study (Hayes et al., 1997) linking countertransference to treatment outcome at termination (as measured by the Counseling Services Assessment; Hurst et al., 1969). Of note, the results of this study only partially supported the link between countertransference and treatment outcome such that countertransference behavior was inversely related to treatment outcome in cases with poor to moderate treatment results but was unrelated to treatment outcome in successful cases (Hayes et al., 1997). Such findings seem to confirm practical wisdom that unmanaged countertransference has a negative impact on treatment outcomes; however, further research is needed to understand how countertransference management mitigates countertransference and contributes to treatment success.

Additional research examining main and interaction effects of countertransference and countertransference management on treatment outcome is of central importance to theory, clinical practice, training, and supervision (Hayes et al., 2018). Building upon and expanding the current study, future research efforts might explore the ways in which countertransference and countertransference management directly versus indirectly influence psychotherapy outcomes via the real relationship and/or working alliance as measured by client, therapist, and external ratings. Other areas of interest include further exploration of client and therapist effects on countertransference, countertransference management, the therapeutic relationship, and treatment outcomes. Research into the affective, behavioral, somatic, and cognitive manifestations of countertransference, their influence on the real relationship and working alliance, and how to

increase therapist awareness of and skillful use of such countertransference reactions to improve therapy outcomes represent still other exciting and important directions for empirical inquiry. As the available literature on countertransference and countertransference management focuses almost exclusively on individual psychotherapy, empirical investigations into the effects of countertransference and countertransference management in group, couples, and family therapy utilizing therapist, client, and external raters are also of great interest and value (Hayes et al., 2018).

Because much of the existing literature on countertransference and countertransference management is cross-sectional, research using experimental and longitudinal designs would advance our understanding of countertransference, countertransference management, and their causal influence on psychotherapy process and outcome. For example, experimental studies might examine how priming attachment anxiety/avoidance interacts with supervisor ratings of countertransference management to predict therapist approach or avoidance behaviors when conducting a series of therapy sessions with a volunteer client. Longitudinal efforts might use therapist self-reported awareness of countertransference reactions and supervisor ratings of countertransference management to predict therapist and client ratings of the real relationship, working alliance, session quality, and progress in therapy across sessions and at termination. The use of structural equation modeling could help to establish causal inferences and offer valuable insight into whether countertransference and countertransference management directly relate to treatment outcomes or indirectly affect outcomes through their joint influence on the therapeutic relationship (Hayes et al., 2018).

Therapist Mindfulness, Meditation, and the Therapeutic Relationship. Much has been theorized about the connections among therapist mindfulness, meditation, and the

therapeutic relationship (Bruce et al., 2010; Nilsson, 2016); however, there is a dearth of empirical research directly exploring these connections. Preliminary research suggests that training therapists in mindfulness meditation can improve therapy outcomes (Grepmair et al., 2007) and point to the need for additional research on therapist mindfulness, meditation, and psychotherapy outcomes. Once established, there also is a need to examine the mechanisms by which mindfulness relates to and improves psychotherapy outcomes. Theorists hypothesized that mindfulness and meditation enhance a therapist's ability to form a strong therapeutic relationship by increasing their ability to empathize, both with the self and with the client. Yet, to our knowledge, only one other study (Ryan et al., 2012) has attempted to test this hypothesis. Results from Ryan and colleagues' study indicate that therapist mindfulness is positively associated with therapist self-affiliation, therapist ratings of the working alliance, and client reported improvements in interpersonal functioning. Research replicating and extending these results may be strengthened by utilizing client, therapist, and external ratings of therapist mindfulness, the working alliance, the real relationship, and therapy outcomes. Additionally, where much of the available literature has tended to focus on the physical/bodily dimensions and mental/minded dimensions of mindfulness, future efforts might also begin to specifically investigate the socioexistential dimensions of mindfulness and its influence on the therapeutic relationship, process, and outcome (Melen, Pepping, & Donovan, 2017; Nilsson, 2016).

As research into therapist mindfulness clarifies the theoretical links among therapist mindfulness, the working alliance, the real relationship, and psychotherapy outcomes, it will be important to specifically design and test mindfulness meditation training programs for therapists in training. Experimental studies can thus begin to answer the question of which mindfulness practices are most helpful to improving the therapeutic relationship and enhancing clinical

outcomes. Likewise, questions of when and how often one must practice mindfulness to gain benefit; how mindfulness cultivated during meditation is carried into and utilized during the psychotherapy hour; and of direct relevance to the current study, how to best use mindfulness practices to regulate, work through, and manage difficult countertransference reactions are of considerable interest (Bruce et al., 2010). To this end, qualitative research and/or mixed methods research conducted with clients, therapists, and their supervisors may offer valuable insights into mindfulness as an empirically based training method for enhancing the therapeutic relationship, managing countertransference, and improving psychotherapy outcomes.

Therapist Mindfulness, Meditation, and Countertransference Management. Our empirical knowledge of the connections among therapist mindfulness, meditation, and countertransference management is limited. Promising preliminary findings point to meaningful relationships among these variables (Fatter & Hayes, 2013). However, additional research using larger samples, different treatment modalities, various research designs, and both self-report and objective measurement is necessary to replicate and extend these findings. Additional cross-sectional research is needed to explore how various facets of self-reported therapist mindfulness interact with meditation experience to influence countertransference management. Future research also could employ longitudinal methods to examine therapist mindfulness as both a baseline predictor of countertransference management and effective therapeutic relating as well as a skill that can be cultivated through clinical training and mindfulness meditation (Fatter & Hayes, 2013). As previously mentioned, the influence of mindfulness training on therapists' awareness of countertransference over time and how this impacts their ability to manage countertransference, resolve conflicts, and relate effectively with their clients is of particular interest for training and supervision.

Emerging empirical evidence for the social foundations of mindfulness provide other interesting directions for future research on therapist mindfulness, countertransference management, and the therapeutic relationship. For example, a recent experimental study conducted by Melen et al. (2017) found that priming attachment anxiety (i.e., by asking participants to imagine/visualize a relationship in which they felt the other person was reluctant to get too close and where they often worried about whether they were cared for by the other person) led to a decrease in state emotion regulation, which was in turn associated with decreased state mindfulness in a sample of undergraduate psychology students. In this study, no such effects were found for priming attachment avoidance (i.e., by asking participants to imagine/visualize a relationship in which they felt uncomfortable, found it difficult to trust the other person, and felt uneasy when the other person tried to get too close to them). Taken together, results suggested that difficulties in emotion regulation mediated the relationship between attachment anxiety and low mindfulness. These findings offer some initial support for the idea that therapist mindfulness, the ability to regulate or manage affective countertransference reactions, and the strength of the therapeutic relationship are interrelated and mutually influence the process of psychotherapy. As of yet, however, these findings have not been replicated or extended with samples of therapists or therapists in training. Future efforts to do so may hold valuable insights for clinical practice, training, and supervision.

Efforts to explore these theoretical connections may benefit from the development and utilization of objective measures of therapist mindfulness as well as self-report measures assessing the quality of meditation practice over time. Neuro-imaging technology such as functional magnetic resonance imaging (fMRI) and electroencephalogram (EEG) also may be used to validate self-report and study the relationships between therapist mindfulness, meditation

practice, and countertransference management. In a similar vein, supervisor ratings of countertransference management capture therapist qualities thought to promote countertransference management but do not directly assess the affective and behavioral components of effective countertransference management. Future research might focus on developing reliable objective and behavioral measures of countertransference reactions and countertransference management.

The Supervisory Relationship. There has been increasing interest into the intra- and interpersonal factors common to all supervisory models, similar to common factors in psychotherapy. Theoretical efforts have been made to extend Gelso and Carter's (1985, 1994) tripartite model to the supervisory relationships. Noting that the supervisory alliance is always triadic in nature and thus far more complex, Watkins (2015) proposed that the supervisory relationship, regardless of theoretical orientation, is composed of the following three components: a supervisor-supervisee working alliance, supervisor-supervisee-client transference-countertransference configuration, and supervisor-supervisee 'real' or personal relationship. Within this model, the supervisor-supervisee working alliance has received the most empirical attention. The supervisor-supervisee-client transference-countertransference configuration and the supervisor-supervisee real relationship have been far less researched. Ripe for empirical study, future efforts might focus on adapting and developing valid and reliable measures of transference, countertransference, and the real relationship for use with clients, supervisees, and supervisors; exploratory/confirmatory factor analysis of the tripartite model of the supervisory relationship; and parallel process research that includes all three perspectives of client, supervisee, and supervisor.

Building upon the current study, it would be of interest to examine mindfulness as a process that unfolds across supervisor-supervisee and supervisee-client dyads and the extent to which this parallel process contributes to psychotherapy outcomes. It also would be interesting to examine the influence of supervisor mindfulness on supervisee mindfulness, the supervisory working alliance, and the real relationship between supervisor and supervisee. Given recent research linking supervisee ratings of the supervisory working alliance to disclosures of countertransference in supervision (Pakdam et al., 2015), exploring supervisor mindfulness, supervisee mindfulness, and the supervisory relationship as predictors of countertransference disclosures, countertransference management, and the therapeutic relationship is warranted. In summary, rigorous efforts utilizing diverse methods of inquiry, including qualitative, longitudinal, experimental, and mixed methods design are necessary to broaden and refine our understanding of the transtheoretical relational aspects of psychotherapy and supervision and how they contribute to clinical outcomes.

Diversity Considerations. Finally, additional research on the influence of therapist and client cultural factors on the real relationship, the working alliance, the transference-countertransference configuration, countertransference management, and psychotherapy process and outcome is needed. One such study (Morales et al., 2018) examining therapist effects on the real relationship and working alliance among White and Racial/Ethnic Minority (REM) clients yielded interesting findings. Using data from 3,263 sessions nested within 144 clients and 19 therapists, they examined client and therapist ratings of the real relationship and working alliance across the course of open-ended psychodynamic psychotherapy. Results from hierarchical linear modeling found that early in treatment (session three) there were no therapist effects due to client REM status. However, as therapy progressed there were significant therapist effects on client

ratings, but not therapist ratings, of the real relationship and working alliance due to client REM status. From the clients' perspectives, client REM status was associated with therapists' ability to develop a strong real relationship and working alliance over time. From the therapists' perspectives, some therapists were better or worse in enhancing the real relationship and working alliance but clients' REM status was not related to therapists' perceived ability to develop the real relationship and working alliance over time. These findings point to the crucial role of the therapist's multicultural and general competencies on effective therapeutic relating. Theoretically, they also offer some early insight into the possible influence of culturally-shaped transference and countertransference dynamics on the real relationship and working alliance between client and therapist. By extension, they have important implications for the role of countertransference management and mindfulness in the culturally competent practice of psychotherapy. It will be valuable to examine these theoretical connections and further, to extend them to other salient cultural and social factors such as sexual orientation, gender identity, social class, and religion.

Study Implications

These findings offer new empirical insights into the role and influence of therapist mindfulness on countertransference management, the real relationship, and the working alliance. Taken together, findings from this study advance our current understanding of psychotherapy as a relational and social healing process. In this respect, results have important implications for theory and practice as well as training and supervision. In this section, these implications are summarized.

Theory and Practice. Study results highlight mindfulness as an important therapist effect with meaningful implications for countertransference management, the real relationship

and working alliance, and in turn, psychotherapy outcomes. Given research linking unmanaged countertransference reactions with poor treatment outcomes (Hayes et al., 2018), it is essential for therapists to regularly reflect upon and assess for transference or countertransference reactions that are influencing and impeding the work of therapy. By way of the therapist's own humanity and inherent vulnerabilities, countertransference reactions are both common and inevitable (Gelso, 2011, 2014). As such, on-going self-reflection and regular consultation with trusted colleagues who can assist with identifying and managing transference and countertransference are key to effective therapeutic relating and ethical clinical practice (Pakdaman, Shafranske, & Falendar, 2015). In this way, reflective practice and therapist mindfulness may be considered an on-going and dynamic interpersonal process as well as a personal trait or ability.

Study findings suggest that mindfulness may also be considered a transtheoretical, intrapersonal process that exerts a significant and meaningful influence on the strength of the therapeutic relationship. Although the current study cannot establish causality, positive correlations between therapist mindfulness and the real relationship and working alliance may suggest that relating to oneself in an open, honest, and non-judgmental manner is facilitative of embracing a similar stance toward one's clients. Thus, therapists who are more mindful are seemingly better able to develop a strong real relationship and working alliance with their clients. Positive correlations between therapist mindfulness and countertransference management suggest that those therapists who are better able to describe and label their genuine thoughts and emotions in the moment and remain non-reactive in the face of personally challenging client concerns may be in a better position to manage and use the transference-countertransference configuration to advance the work of therapy.

Study findings offer preliminary empirical support for mindfulness training and meditation practice as potentially useful strategies for coping with countertransference and facilitating strong therapeutic relationships. In light of empirical evidence documenting the influence of countertransference management (Hayes et al., 2011; Hayes et al., 2018), the real relationship (Gelso et al., 2018), and the working alliance (Horvath et al., 2011) on psychotherapy processes and outcomes, study results suggest that meditation may hold promise for clinicians who are looking for ways to improve their efficacy and enhance client outcomes. Although it warrants further research, regular meditation practice may be of benefit to therapists who struggle to establish strong therapeutic relationships and experience significant client drop out. To the extent that their unresolved conflicts are impeding their ability to relate effectively with their clients, meditation practice might also assist therapists in identifying their personal limitations, encourage them to seek their own psychotherapy, and/or make appropriate adjustments with regard to their case load and/or scope of practice. Likewise, meditation and other mindfulness-based practices may be helpful for beginning therapists who are just learning to identify their personal vulnerabilities, develop in the moment awareness of countertransference-based reactions, and use such reactions to understand and guide therapeutic change. To this end, study findings have important implications for clinical training and supervision.

Training and Supervision. As the science and practice of psychology advances beyond the limitations of a specific ingredients approach toward a deeper understanding of the social and relational mechanisms of therapeutic change, so too must our models of clinical training (Elkins, 2012; Budge & Wampold, 2015). Citing a growing body of research documenting the influence of the real relationship, working alliance, transference, and countertransference on

psychotherapy process and outcome, regardless of theoretical orientation, researchers have highlighted the need to integrate a more complex understanding of the therapeutic relationship into clinical training (Gelso, 2014). In response to questions of how therapists can work to strengthen the therapeutic relationship, some scholars have suggested that mindfulness-based practices and meditation be included into clinical training as a means of promoting meta-cognition and interpersonal attunement (Bruce et al., 2010; Fatter & Hayes, 2013; Fauth et al., 2007). Although further research is necessary, results from the current study provide some initial empirical support for these training recommendations.

Given the idiosyncratic and often personal nature of countertransference-based reactions (Gelso, 2014) and findings that therapists in training struggle to identify and manage countertransference (Hill et al., 2007; Howard et al., 2006), results from this study have relevance to clinical supervision, where concerns related to countertransference are likely to surface. Based upon study findings, it could be inferred that therapists in training who are better able to describe their genuine inner experiences, respond versus react, and relate more effectively with their clients are likely to carry these same strengths into supervision. To the extent that these therapist qualities also facilitate the open disclosure of countertransference reactions in supervision, they may further enhance countertransference management such that therapist disclosure of countertransference in supervision is thought to play a pivotal role in identifying, exploring, and managing countertransference reactions (Pakdaman et al., 2015).

Although additional research is needed, these findings might offer some insights into supervision practices. Supervisors who are more mindful also may be better at facilitating a strong supervisory relationship, thereby increasing the likelihood of therapist countertransference disclosures and promoting countertransference management. Indeed, prior research that

examined the influence of the supervisory relationship on countertransference disclosures showed a positive association between trainee ratings of the supervisory alliance and reported comfort and likelihood of disclosing countertransference reactions (Pakdaman et al., 2015). Supervisors who are looking to help therapists in training relate more effectively to their clients might benefit from strengthening the supervisory relationship. Likewise, supervisors might consider using meditation or other mindfulness-based practices as a supplement to clinical practice and supervision.

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Appendix A

Demographics: Therapist Form

Please complete the following demographic questionnaire about your personal, educational, spiritual, and clinical background.

Age: _____

Gender:

_____Female

_____Male

_____Trans/Gender Non-Conforming

_____Other (Please specify): _____

Ethnicity:

_____Asian or Asian American, including Chinese, Japanese, and others

_____Black or African American

_____Hispanic or Latino, including Mexican American, Central American, and others

_____White, Caucasian, Anglo, European American

_____American Indian/Native American/Pacific Islander

_____Mixed

_____Other (Please specify):_____

What is your current status as a trainee?

_____Masters student in counseling or clinical psychology

_____Doctoral student in counseling or clinical psychology

_____Pre-doctoral intern in counseling or clinical psychology

_____Post-doctoral fellow in counseling or clinical psychology

How many years of graduate training in counseling/clinical psychology have you completed?

_____Less than one year

_____One year

_____Two years

_____Three years

_____Four years

_____Five or more years

How long have you been providing individual psychotherapy?

_____Less than one year

_____One year

_____Two years

_____Three years

_____Four years

_____Five or more years

Approximately how many total hours of supervised clinical work have you completed across your training? _____

What is your primary theoretical orientation?

_____Behavioral

_____Cognitive

_____Cognitive-Behavioral

_____Eclectic

_____Existential

_____Gestalt

_____Psychoanalytic

_____Psychodynamic

_____Humanistic

_____Systemic

_____Feminist

_____Other (Please specify):_____

What type of treatment setting are you currently working in?

_____Hospital

_____Outpatient Clinic

_____University Counseling Center

_____Community Counseling Center

_____Forensic

_____Other (Please specify):_____

On average, how many hours per week do you currently meet with clients? _____

How many hours of supervision do you receive per week? _____

Do you regularly review video/audio recordings of your client therapy sessions with your current supervisor?

_____Yes

_____No

How would you rate the quality of your current supervision?

_____Excellent

_____Good

_____Neutral

_____Poor

_____Very Poor

Do you consider yourself religious or spiritual?

_____Yes

_____Somewhat

_____No

If yes, what religious or spiritual beliefs do you currently practice? (Please specify):_____

Do you currently practice mindfulness meditation?

_____Yes

_____Sometimes

_____No

How long have you been practicing mindfulness meditation?

_____Less than one year

_____One to three years

_____Three to five years

_____Five to ten years

_____Ten years or more

How frequently do you meditate per week? _____

Do you regularly engage in other relaxation or stress reduction exercises like yoga, tai-chi or progressive muscle relaxation?

_____Yes

_____No

Are you or have you ever been in individual psychotherapy?

_____Yes

_____No

Has a clinical supervisor ever recommended that you seek personal therapy?

_____Yes

_____No

Have you ever sought psychotherapy at the recommendation of a clinical supervisor?

_____Yes

_____No

Appendix B

Five Facet Mindfulness Questionnaire (FFMQ; Baer et al., 2006)

Please rate each of the following statements using the scale provided. Write the number in the blank that best describes your own opinion of what is generally true for you.

1	2	3	4	5
Never or very rarely true	**Rarely true**	**Sometimes true**	**Often true**	**Very often or always true**

_____ 1. When I'm walking, I deliberately notice the sensations of my body moving.
_____ 2. I'm good at finding words to describe my feelings.
_____ 3. I criticize myself for having irrational or inappropriate emotions.
_____ 4. I perceive my feelings and emotions without having to react to them.
_____ 5. When I do things, my mind wanders off and I'm easily distracted.
_____ 6. When I take a shower or bath, I stay alert to the sensations of water on my body.
_____ 7. I can easily put my beliefs, opinions, and expectations into words.
_____ 8. I don't pay attention to what I'm doing because I'm daydreaming, worrying, or otherwise distracted.
_____ 9. I watch my feelings without getting lost in them.
_____ 10. I tell myself I shouldn't be feeling the way I'm feeling.
_____ 11. I notice how foods and drinks affect my thoughts, bodily sensations, and emotions.
_____ 12. It's hard for me to find the words to describe what I'm thinking.
_____ 13. I am easily distracted.
_____ 14. I believe some of my thoughts are abnormal or bad and I shouldn't think that way.
_____ 15. I pay attention to sensations, such as the wind in my hair or sun on my face.
_____ 16. I have trouble thinking of the right words to express how I feel about things
_____ 17. I make judgments about whether my thoughts are good or bad.
_____ 18. I find it difficult to stay focused on what's happening in the present.
_____ 19. When I have distressing thoughts or images, I "step back" and am aware of the thought or image without getting taken over by it.
_____ 20. I pay attention to sounds, such as clocks ticking, birds chirping, or cars passing.

1	2	3	4	5
Never or very rarely true	**Rarely true**	**Sometimes true**	**Often true**	**Very often or always true**

_____ 21. In difficult situations, I can pause without immediately reacting.

_____ 22. When I have a sensation in my body, it's difficult for me to describe it because I can't find the right words.

_____ 23. It seems I am "running on automatic" without much awareness of what I'm doing.

_____24. When I have distressing thoughts or images, I feel calm soon after.

_____ 25. I tell myself that I shouldn't be thinking the way I'm thinking.

_____ 26. I notice the smells and aromas of things.

_____ 27. Even when I'm feeling terribly upset, I can find a way to put it into words.

_____ 28. I rush through activities without being really attentive to them.

_____ 29. When I have distressing thoughts or images I am able just to notice them without reacting.

_____ 30. I think some of my emotions are bad or inappropriate and I shouldn't feel them.

_____ 31. I notice visual elements in art or nature, such as colors, shapes, textures, or patterns of light and shadow.

_____ 32. My natural tendency is to put my experiences into words.

_____ 33. When I have distressing thoughts or images, I just notice them and let them go.

_____ 34. I do jobs or tasks automatically without being aware of what I'm doing.

_____ 35. When I have distressing thoughts or images, I judge myself as good or bad, depending what the thought/image is about.

_____ 36. I pay attention to how my emotions affect my thoughts and behavior.

_____ 37. I can usually describe how I feel at the moment in considerable detail.

_____ 38. I find myself doing things without paying attention.

_____ 39. I disapprove of myself when I have irrational ideas.

Appendix C

The Real Relationship Inventory-Therapist Form (Gelso et al., 2005)

Please complete the following items with respect to the three most recent clients (to be designated Client 1, 2, & 3) you met with for psychotherapy and with whom you have seen for at least three individual therapy sessions.

For Client X, please indicate the degree to which you agree with each statement using the following scale:

1	2	3	4	5
Strongly disagree	**Disagree**	**Not sure**	**Agree**	**Strongly agree**

_____ 1. My client and I are able to be genuine in our relationship.
_____ 2. I hold back significant parts of myself.
_____ 3. I feel there is a "real" relationship between us aside from the professional relationship.
_____ 4. My client and I are honest in our relationship.
_____ 5. We feel a deep and genuine caring for one another.
_____ 6. My client has respect for me as a person.
_____ 7. There is no genuinely positive connection between us.
_____ 8. My client's feelings toward me seem to fit who I am as a person.
_____ 9. I do not like my client as a person.
_____ 10. The relationship between my client and me is strengthened by our understanding of one another.
_____ 11. My client and I have difficulty accepting each other as we really are.
_____ 12. I have difficulty being honest with my client.

Appendix D

Working Alliance Inventory-Short Revised (Hatcher & Gillaspy, 2006)

Please complete the following items with respect to the three most recent clients (to be designated Client 1, 2, & 3) you met with for psychotherapy and with whom you have seen for at least five individual therapy sessions.

With respect to Client X, please rate each of the following statements using the scale provided:

1	2	3	4	5
Never or very rarely true	**Rarely true**	**Sometimes true**	**Often true**	**Very often or always true**

_____ 1. I believe my client likes me.

_____ 2. We are working toward mutually agreed upon goals.

_____ 3. I appreciate my client as a person.

_____ 4. We agree on what is important for my client to work on.

_____ 5.We have established a good understanding of the kinds of changes that would be good for them.

_____ 6. My client believes the way we are working on their problems is correct.

_____ 7. My client and I respect each other.

_____ 8. I feel confident that the things we do in therapy will help my client accomplish the changes that they desire.

_____ 9. My client and I collaborate on setting goals for therapy

_____ 10. I respect my client even when they do things that I do not approve of.

_____ 11. As a result of our sessions, my client is clearer as to how they might be able to change.

_____ 12. What we are doing in therapy gives my client new ways of looking at their problem.

Appendix E

Supervisor Demographic Form

Age: _____

Gender:

_____Female

_____Male

_____Trans/Gender Non-Conforming

_____Other (Please specify):_____

Ethnicity:

_____Asian or Asian American, including Chinese, Japanese, and others

_____Black or African American

_____Hispanic or Latino, including Mexican American, Central American, and others

_____White, Caucasian, Anglo, European American

_____American Indian/Native American/Pacific Islander

_____Mixed

_____Other (Please specify): _____

How many years have you been working as a licensed professional counselor or psychologist?

_____I am not yet licensed

_____Less than one year

_____One to three years

_____Three to five years

_____Five to ten years

_____Ten years or more

Have you received formal training in providing clinical supervision to trainees?

_____Yes

_____No

If yes, how many years of training in clinical supervision have you completed?

_____Less than one year

_____One to three years

_____Three to five years

_____Five to ten years

_____Ten years or more

If yes, what type of supervision training did you complete? Check all that apply.

_____Coursework

_____Independent reading

_____Live observation of supervision

_____Videotape review of supervision

_____Individual supervision of supervision

_____Group supervision of supervision

Are you currently receiving supervision of supervision?

_____Yes

_____No

How many years of training in clinical supervision have you completed?

_____Less than one year

_____One to three years

_____Three to five years

_____Five to ten years

_____Ten years or more

How many years of experience do you have in providing clinicial supervision to trainees?

_____Less than one year

_____One to three years

_____Three to five years

_____Five to ten years

_____Ten years or more

What is your primary theoretical orientation? (Please specify)

What type of treatment setting are you currently working in?

_____Hospital

_____Outpatient Clinic

_____University Counseling Center

_____Community Counseling Center

_____Forensic

_____Other (Please specify): _____

On average, how many hours per week do you currently meet with clients? _____

On average, how many hours per week do you currently meet with trainees for individual or group supervision? _____

How often do you meet with the trainee involved in the present study for individual supervision?

_____Two or more hours per week

_____One hour per week

_____One hour every two weeks

_____One hour per month

_____Less than one hour per month

Approximately how long have you supervised the trainee involved in the present study?

_____Less than three months

_____Three to six months

_____Six to nine months

_____Nine to twelve months

_____One year or more

Have you directly observed the clinical work of the trainee involved in the present study?

_____Yes

_____No

If yes, please specify the methods of direct observation (Check all that apply)

_____Live observation

_____Co-therapy

_____Audiotape review

_____Videotape review

If yes, approximately how many therapy sessions have you observed through live observation, co-therapy, and/or video/audio recording?

_____One to three sessions

_____Three to five sessions

_____Five to ten sessions

_____Ten or more sessions

How would you rate the quality of the supervisory relationship between you and the trainee involved in the present study?

_____Excellent

_____Good

_____Neutral

_____Poor

_____Very Poor

Do you consider yourself religious or spiritual?

_____Yes

_____Somewhat

_____No

If yes, what religious or spiritual beliefs do you currently practice? (Please specify): _____

Do you currently practice mindfulness meditation?

_____Yes

_____No

How long have you been practicing mindfulness meditation?

_____Less than one year

_____One to three years

_____Three to five years

_____Five to ten years

_____Ten years or more

How frequently do you meditate per week? _____

Do you regularly engage in other relaxation or stress reduction exercises like yoga, tai-chi or progressive muscle relaxation?

_____Yes

_____No

Are you or have you ever been in individual psychotherapy?

_____Yes

_____No

Has a clinical supervisor ever recommended that you seek personal therapy?

_____Yes

_____No

Have you ever sought psychotherapy at the recommendation of a clinical supervisor?

_____Yes

_____No

Have you ever referred a supervisee to individual psychotherapy?

_____Yes

_____No

Have you referred the supervisee involved in the present study for individual psychotherapy?

_____Yes

_____No

Appendix F

Countertransference Management Scale (CMS; Perez-Rojas et al., in press)

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

1	2	3	4	5
Strongly disagree	**Disagree**	**Not sure**	**Agree**	**Strongly agree**

_____ 1. Grasps theoretically clients' dynamics in terms of what goes on in the therapeutic relationship.

_____ 2. Effectively connects strands of clients' material in developing conceptualizations of clients.

_____ 3. Is able to conceptualize clients' dynamics clearly.

_____ 4. Uses their theoretical understanding of the client-therapist relationship to inform the work during the therapeutic hour.

_____ 5. Understands how their emotions, thoughts, and behaviors in session are connected.

_____ 6. Effectively sorts out how their feelings relate to clients' feelings.

_____ 7. Can identify the motives behind their behaviors in session.

_____ 8. Is able to step into clients' inner world.

_____ 9. Deeply understands clients from clients' point of view.

_____ 10. Understands the basis of their feelings, thoughts, and behaviors in session.

_____ 11. Understands the basis for own atypical reactions to clients.

_____ 12. Does not let anxiety overwhelm them in the psychotherapy hour.

_____ 13. Has appropriate confidence as a person during the psychotherapy hour.

_____ 14. Presents a consistent sense of self in the therapeutic hour.

_____ 15. Demonstrates calm in the face of difficult client material.

_____ 16. Maintains a firm sense of who they are as a person in the sessions.

_____ 17. Deals effectively with their anxiety when working with difficult client problems.

_____ 18. Regulates their own nervousness well during sessions.

_____ 19. Has a well-integrated self during sessions

_____ 20. Allows themself to feel a range of affect without getting overly anxious.

_____ 21. Recognizes the boundaries between themself and their clients during the psychotherapy hour.