The Effects of Sex Role Orientation on Countertransference Behavior

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THE EFFECTS OF SEX ROLE ORIENTATION ON COUNTERTRANSFERENCE BEHAVIOR

by

Scott T. Luppe

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Doctor of Education
Department of Counselor Education
and Counseling Psychology

Western Michigan University
Kalamazoo, Michigan
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THE EFFECTS OF SEX ROLE ORIENTATION ON COUNTERTRANSFERENCE BEHAVIOR

Scott T. Luppe, Ed.D.
Western Michigan University, 1990

The occurrence of countertransference within the therapeutic relationship has been examined from clinical and empirical perspectives, and considerable insight has been gained regarding the operation and monitoring of these phenomena. Empirical investigation has shown that these attitudes and behaviors can be quantified, and that therapists' increased understanding of the presence of countertransference can result in less countertransference behaviors (Schlesinger, 1984; Robbins & Jolkovski, 1987).

The therapist's sex role orientation is an attribute that has never been considered in relation to countertransference. Bem (1974) and Spence, Helmreich, and Stapp (1975) have proposed conceptualizations for understanding differences in sex role issues and have developed instruments which measure the constructs of individuals' sex role orientations. Such frameworks provide meaningful contexts for the examination of countertransference phenomena in relation to these therapist variables.

This analogue study examines the effects of the sex
role orientation of therapists on countertransference behavior, operationalized in this study as withdrawal of therapist involvement, and understood as a negative form of countertransference. Fifty-one graduate students in a counselor training program were randomly selected and assessed for their sex role orientations using the short form of the Bem Sex Role Inventory (BSRI) (Bem, 1981a). Using a procedure developed by Jolkovski (1989), they were also asked to view two videotaped client presentations designed to elicit countertransference responses, choosing from multiple choice responses that they would make if they were the client's therapist. The results were analyzed using a one-way Analysis of Variance (ANOVA) to determine if differences in sex role orientation are related to levels of countertransference behavior, and in this study no significant differences were found regarding this relationship. Subsequent post-hoc analyses on demographic variables revealed a significant relationship between the number of supervision hours reported by the therapist and amount of countertransference behavior with one of the client presentations. Discussion of possible reasons for nonsignificant results included limitations of the construct used to measure countertransference and suggestions were made for future research.
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The effects of sex role orientation on countertransference behavior

Luppe, Scott T., Ed.D.
Western Michigan University, 1990

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The author wishes to express his gratitude to those who have been so helpful throughout the process of this study. From its inception through the final stages, E. L. Trembley offered valuable insight and feedback, as well as moral support that was crucial to the development of the project. The relative ease with which data collection was accomplished would not have been possible without the gracious cooperation and assistance of Robert Betz, Director of The Center for Counseling and Psychological Services at Western Michigan University, Kalamazoo, and his very capable staff. The expertise of Robert Brashear and his exceeding generosity with his time, energy and support made the analysis of the data an almost enjoyable experience.

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Scott T. Luppe
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CHAPTER I

INTRODUCTION

Countertransference is a phenomenon that has been observed and scrutinized by psychoanalysts and therapists for many years. When Freud (1910/1964) first recognized and wrote about it, he did not elaborate much on the notion other than to say that it was, "a result of the patient's influence on his [physician's] unconscious feelings, and we are almost inclined that he shall recognize this countertransference in himself and overcome it" (pp. 144-145). Others have written to elaborate on the classical view of this clinically observed phenomenon, maintaining that countertransference was the result of the analyst's unconscious, resistive reactions to the patient's transference (Fenichel, 1941; Glover, 1955; Reich, 1951, 1960; Stern, 1924). This view continued to be the accepted understanding of countertransference until persons like Little (1951, 1960), Heimann (1950), Racker (1968), Kernberg (1965) and others advocated that a broader definition be used, including all of the therapist's conscious and unconscious reactions to the client. These authors were also among the first to suggest that countertransference was something which the analyst could, and
should, be aware of and use in understanding the client. Although this view has not been totally accepted, it is more accepted than the classical view, and certainly has been explored more vigorously beyond the doors of the consulting room (Epstein & Feiner, 1979).

This gradual shift in the understanding of what constitutes countertransference facilitated increases in the empirical examination of its occurrence. Researchers began to investigate ways of operationalizing and quantifying countertransference, and although there has been continued debate on the methods and findings, a review of the literature suggested that almost all writers agreed that a distinction must be made between countertransference feelings and attitudes and the overt behaviors that result from it (Robbins & Jolkovski, 1987). Countertransference feelings and attitudes refer to the conscious and unconscious processes of the therapist in response to a client, whereas countertransference behaviors refer to the overt behaviors manifested by a therapist in session as a result of those attitudes and feelings. This study will focus primarily on countertransference behaviors.

One of the key contributions from empirical investigation has been an examination of the relationships between therapist traits and characteristics and countertransference (Bandura, 1956; Donner & Schonfield, 1975; Heller, Meyers, & Kline, 1963; Milliken & Kirchner, 1971;
Strupp, 1958; Yulis & Kiesler, 1968). Studies reported by these authors have observed that the presence of some therapist traits increased the potential for countertransference behavior. Another key finding has been that therapists had differing countertransferential responses to varying client types (Peabody & Gelso, 1982; Robbins & Jolkovski, 1987; Yulis & Kiesler, 1968), which suggests that client presentation may interact with the therapist's attitudes, traits and characteristics in eliciting differential levels of countertransference. These research efforts have provided valuable, if under-utilized, information for therapists in terms of self awareness, as well as for supervisors and instructors regarding potential training issues.

In explorations of factors influencing countertransference, therapist variables which have not been carefully considered are the effects of gender and sex role orientation. In several studies, (Abramowitz, Abramowitz & Weitz, 1976; Abramowitz, Abramowitz, Roback, Corney & McKee, 1976; Abramowitz, Roback, Schwartz, Yasuma, Abramowitz & Gomes, 1976), gender has been examined as a factor in countertransference, and although some differences were found in relation to type of countertransference between males and females, it was suggested that these differences may be difficult to generalize. Other studies have included both male and female therapists in explorations of
countertransference, but have not focused on the specific gender differences (Milliken & Kirchner, 1971; Robbins & Jolkovski, 1987; Yulis & Kiesler, 1968). Howard, Orlinsky and Hill (1969) did investigate some of the differences in gender by attempting to identify relationships between the client's feelings and behaviors and the therapist's feelings in the therapy session. They found that male and female therapists differed signifi-cantly in their report of countertransference feelings in response to patient presentation. This suggests that a relationship may exist between the therapist's gender and countertransference. However, in light of the studies which have specifically considered this relationship, one must wonder what the nature of this relationship is, and how, and with what, it interacts.

This study proposes to examine the relationship between countertransference behavior and sex role orientation. Researchers in the area of sex role orientation have productively explored therapists' attitudes and behaviors as a function of their sex role orientations and have found this approach to be much more useful than a straightforward examination of gender differences. The study of therapist gender (male and female) has revealed that although attitudinal and behavioral differences may exist (Abramowitz, Abramowitz & Weitz, 1976; Buczek, 1981), it is not always clear what these differences
represent. Explorations of the therapist's sex role orientation (the degree to which the therapist adheres to socially defined masculine and feminine roles) has been much more productive, both theoretically and empirically, in examining what these differences are (Bem, 1974, 1975, 1977, 1981b; Fong & Borders, 1985; Fong, Borders, & Neimeyer, 1986; Spence, Helmreich & Stapp, 1975). These authors' conceptual formulations and research efforts have shown that differences can be observed between sex role orientations that have not been observed when considering gender alone, suggesting that exploring differences between therapists is more useful when considering sex role orientations than when gender is the only consideration.

Although relatively little attention has been given to the theoretical connections between sex role orientation and countertransference, there does seem to be foundation for such a connection. The evolving understanding which has occurred in countertransference phenomena through this century has necessitated examination of all of the potential sources from which it may develop. The more broadened, totalistic view described by Kernberg (1965) suggests that the sources of countertransference may be understood not only in terms of a psychodynamic perspective of intrapsychic and interpersonal functioning, but that all theoretical understandings may be used to inform what is known about the processes involved in the
therapeutic endeavor (Gelso & Carter, 1985). As previously mentioned, a number of researchers have already examined therapist attributes which may be related to countertransference phenomena, including some who have given attention to the contribution of gender (Abramowitz, Abramowitz & Weitz, 1976; Abramowitz, Abramowitz, Roback, Corney & McKee, 1976; Buczek, 1981). In light of this progression of theoretical and research developments, a further step seems justified in the examination of sex role orientation and its contribution to countertransference.

Examining countertransference in relation to the sex role orientation of the therapist can provide insight into one of the most significant, as well as obvious, therapist attributes. Differences between male and female therapists exist in the ways they relate to clients (Abramowitz, Abramowitz, Roback, Corney & McKee, 1976; Abramowitz, Roback, Schwartz, Yasuma, Abramowitz & Gomes, 1976; Howard et al., 1969; Kimberlin & Friesen, 1980), and yet theoretical and empirical explorations of countertransference have consistently supported the notion that countertransference is not subject to gender, age or theoretical orientation of the therapist (Peabody & Gelso, 1982; Robbins & Jolkovski, 1987; Singer & Luborsky, 1977). Exploration of this area must attempt to understand more of why this disparity between reports exists, and whether
there actually are gender related differences in the occurrence of countertransference in therapists. Studying countertransference by examining gender has not been particularly productive, but exploring the contribution of the therapist's sex role orientation may prove more useful, as it has in other examinations of therapist attitudes and behaviors (Bem, 1974, 1975, 1977, 1981b; Fong & Borders, 1985; Fong et al., 1986; Spence et al., 1975).

If it can be shown that the sex role orientation of the therapist has some relationship to the countertransference behaviors elicited by the type of client presentation, then careful consideration must be given to the effects on process and outcome of the therapeutic endeavor. Studies have provided useful constructs for examining these relationships (Bandura, 1956; Bem, 1974, 1981a; Jolkovski, 1989; Peabody & Gelso, 1982; Robbins & Jolkovski, 1987; Yulis & Kiesler, 1968). However, none have examined these constructs together, despite their implicit relationship. Exploration of the effects of sex role orientation and gender on countertransference behavior would contribute to the existing literature. An elaboration of these factors and their influence would have implications for counseling psychology training programs, as well as for increasing clinical understanding of countertransference phenomena.
Statement of the Problem

The problem which this research will address is that of clarifying the nature of the relationships between the therapist's sex role orientation and countertransference behavior, understood in this particular study as the negative withdrawal of therapist involvement from the client, in response to type of client presentation.

Countertransference

One of the factors that has made the empirical study of countertransference so difficult is the disagreement on the definitions to be used. Epstein and Feiner (1979) have pointed out that the classical view of countertransference consists of a much more narrow view of the concept, while the totalistic view embraces a much broader understanding of countertransference. Freud's (1910/1964) original proposal, that the countertransference was something to be overcome, has given a negative stigma to the subject, and perhaps this has caused many to avoid the study of this phenomenon. Racker (1968) has suggested that empirical study of countertransference has been ignored because of the therapist's and investigator's own countertransference, that it is threatening to consider, and possibly acknowledge, the presence of such phenomena within oneself.
In addition to the difficulty in agreement on definitions, it has been difficult for many to decide how to measure countertransference. If a classical definition is accepted, then the study is to be of conscious and unconscious reactions in the therapist in response to the client's transference (Fleiss, 1953; Glover, 1955; Reich, 1951, 1960). The most logical way to measure this is through the clinician's own observation of it, since no other can actually know the therapist's unconscious reaction and can only guess at the conscious reactions that are not observable (Giovacchini, 1989; Snyder & Snyder, 1961). Conversely, if a broader definition of countertransference is used, the difficulty becomes contamination of the therapeutic relationship in the very effort to study the phenomenon. In order to study the therapist's behaviors and how they may be resulting from either the client's dynamics or the therapist's own characteristics, traits, attitudes or values, it is necessary to implement a procedure that somehow intrudes into the therapeutic relationship (Greenberg & Pinsof, 1986). The therapist must make self reports of some kind, or observations must be made through mirrors, using audio, audio-visual, or some other method to measure countertransference, all of which intrude into the therapeutic relationship and may alter the very dynamics which are under consideration. Analogue studies also have limitations in that they are
difficult to generalize to the therapeutic context, since the countertransference which is observed in such studies is not in response to an actual client in a live therapy situation. Nevertheless, empirical investigation has been undertaken in the area of countertransference. While the results must be carefully considered with regard to precisely what it is that they measure, and how they can be applied to other therapeutic contexts, they do provide insight into this clinical phenomenon.

A variety of approaches has been used to study countertransference. Clinical observation has been one of the most prominent, with authors describing their experiences in the context of theoretical propositions (Giovacchini, 1989; Little, 1951; Racker, 1968; Reich, 1951). Empirical literature has examined countertransference by factor analyzing it (Cutler, 1958; Fiedler, 1951), studying the therapist's report of it (Freemont & Anderson, 1988; Howard et al., 1969; McClure, 1984), and developing analogue studies which simulated conditions under which it may occur (Peabody & Gelso, 1982; Robbins & Jolkovski, 1987; Yulis & Kiesler, 1968). Some have measured constructs believed to represent it, such as therapist's anxiety (Donner & Schonfield, 1975; Milliken & Kirchner, 1971; Yulis & Kiesler, 1968), therapist's withdrawal from the patient (Bandura, 1956; Heller et al., 1963; Milliken & Kirchner, 1971; Robbins & Jolkovski,
1987; Strupp, 1958; Yulis & Kiesler, 1968), and the therapist's nontherapeutic, affective responses to the client (Ehrlich & Bauer, 1967; Tourney et al., 1966).

An approach that has been used productively in studying countertransference has been to examine its relationship to therapist's traits, personality characteristics and attitudes, such as areas of personality conflict (Cutler, 1958), the ways anger is expressed (Bandura, 1956; Gaminsky & Fairwell, 1966), others' judgments concerning the therapist's interpersonal competencies (Fiedler, 1951), level of empathy (Peabody & Gelso, 1982; Strupp, 1958), levels of anxiety (Milliken & Kirchner, 1971; Yulis & Kiesler, 1968), and amount of self awareness (Schlesinger, 1984). These studies have substantiated the existence of a relationship between countertransference and certain therapist characteristics.

With the many studies that have been conducted to better understand countertransference, very few have considered what seems to be one of the most obvious sources of potential difference between therapists: that represented by the gender of the therapist. This may be reflective of the nature of the traditional psychoanalytic endeavor, being one in which the analyst strives to be neutral and asexual (Kernberg, 1965; Langs, 1976; Racker, 1968). Those who have examined the effects of the gender of the therapist have found that some differences do exist
(Abramowitz, Abramowitz & Weitz, 1976; Abramowitz, Roback, Schwartz, Yasuma, Abramowitz & Gomes, 1976; Buczek, 1981; Howard et al., 1969; Kimberlin & Friesen, 1980), but have not elaborated on this phenomenon. It is apparent that a better understanding of the contribution of such factors would be productive. It would enhance the therapist's ability to anticipate countertransference, possibly using the awareness of it to a therapeutic advantage. It may also suggest revisions in current clinical and training settings, especially if it is found that greater countertransference can be expected in relation to specific sex role factors. But to date, gender and sex role orientation have received little attention as factors for understanding the relationship between countertransference and therapist variables.

Sex Role Orientation and Gender

From infancy, children are socialized, with the most apparent form of that socialization process occurring according to sex roles. Boys and girls are reinforced from very early ages, through both external and internal pressures, to acquire sex specific skills and behaviors, as well as to internalize self conceptualizations which society identifies as male and female, masculine and feminine (Barry, Bacon, & Child, 1957). Gender has an important role to play in the process and may be examined.
for its effects on countertransference behaviors, but perhaps a more useful and informative construct for such examination is the sex role orientation of the therapist.

The process of sex role socialization has been examined from a variety of perspectives, and has been reviewed by numerous authors including Bem (1981b). She notes that Sears, Rau and Alpert (1965) considered it from a psychoanalytic framework, where the emphasis was placed on identification with the parent of the same sex. Mischel (1970) looked at the process through a social learning theory model, suggesting that through the reinforcement of explicit rewards, punishments, and observational learning through modeling, males and females are socialized to be masculine or feminine. Kohlberg's (1966) cognitive-developmental perspective offered that once individuals have labeled themselves as male or female, they proceed to socialize themselves in sex appropriate ways. Regardless of precisely how the socialization process occurs, the development of an individual's sex role orientation has some impact in facilitating differing ways of functioning cognitively, behaviorally, and affectively, resulting in various interpersonal relational styles (Fairbairn, 1962; Guntrip, 1971; Kegan, 1982; Winnicott, 1965).

Bem (1981b) has observed that some innate differences between sexes obviously exist, such as anatomy, reproductive functions, and to some extent the physical capacities
which lead to assumption of roles in labor. To these differences, societal prescription adds other distinctions of sex role appropriateness. Through the process of socialization, males and females develop attitudes, behaviors, traits and even ways of thinking which are differentially related to gender (Bem, 1974, 1981b; Block, 1984; Chodorow, 1978; Gilbert, 1987; Gilligan, 1982; Miller, 1976). This has varying effects on the ways that males and females perceive, organize and process incoming stimuli (Bem, 1981b; Deaux & Major, 1977; Lippa, 1977; Neisser, 1976; Nisbett & Ross, 1980), and on the ways individuals in general come to relate to others (Fairbairn, 1962; Guntrip, 1971; Kegan, 1982; Winnicott, 1965).

Bem (1974) and Spence et al., (1975) in both theoretical writing and empirical studies, have contributed to increased understanding of sex role orientation. In their conceptualization, individuals can be assessed and categorized as Masculine, Feminine, Androgynous or Undifferentiated in their sex role orientation. A Masculine sex role orientation reflects more instrumental roles that are associated with task-orientation, goal-directedness and independence. The Feminine sex role is representative of more expressive roles, such as nurturance and receptivity, which is represented by traits that are affective, supportive and focused toward others. The Androgynous sex
role orientation is an integration of both masculine and feminine qualities, resulting in an individual with capacities in both sex role dimensions. The Undifferentiated orientation represents persons who do not endorse significant masculine or feminine traits.

This conceptualization has resulted in a theoretical framework and in an instrument which measured these constructs (Bem, 1981a). The Bem Sex Role Inventory (BSRI) allows for classification of levels of stereotypical masculine and feminine characteristics, resulting in persons with sex role orientations of Masculine, Feminine, Androgynous, and Undifferentiated. This instrument has proven useful and meaningful in research assessing sex role differences.

Using this conceptualization, Bem (1981b) also discussed the cross-sex type, where an individual of either gender endorses characteristics that are more stereotypical for the opposite gender. When individuals endorse proportionally more characteristics which are consistent with their own gender than the opposite gender, they are considered to be sex typed.

Kohlberg (1966), Kagan (1964), and Bem (1974, 1981b) have proposed that persons with sex typed orientations (masculinity or femininity) may be more motivated to maintain consistency between their behaviors and their own sex role orientation than an individual with more
androgynous sex role orientation, thus limiting them in their available responses. This has been corroborated in several studies, with the results showing that the andrognous individuals appeared to have a broader repertoire of behaviors (Bem, 1975; Bem, Martyna, & Watson, 1976), were more comfortable with cross sexed activities (Bem & Lenney, 1976), scored higher more consistently on measures of self esteem (Andersen, 1976; Antill & Cunningham, 1979; Bem, 1977; Spence et al., 1975); and reported less anxiety in anticipating assertive behaviors (Currant, Dickson, Anderson, & Faulkender, 1979). Persons with androgynous orientations have also demonstrated more effective interpersonal functioning styles and have been more adept in complex social situations (Kelly, O'Brien, & Hosford, 1981; Kelly, O'Brien, Hosford, & Kinsinger, cited in Kelly & Worell, 1977). Although in these studies Masculine and Feminine sex types have both been lower in their ratings than the Androgynous groups, it has been observed that the Masculine group is the least effective in areas measuring empathy (Abramowitz, Abramowitz, Roback, Corney & McKee, 1976) and self disclosure (Fong et al., 1986; Jourard, 1971), and Feminine groups have been least effective in areas measuring assertiveness (Currant et al., 1979) and independence (Bem, 1975). Differences between these sex role orientations have also been observed in counseling settings (Buczek, 1981, 1986; Fong & Borders, 1985; Fong
et al., 1986; Jourard, 1971).

The results of studies including Undifferentiated and cross-sex typed orientations suggested specific expectancies, as well. Undifferentiated individuals have been found to be more inhibited in their behavioral responses (Bem, 1977; Bem & Lenney, 1976), to have scored lowest on multifactor self concept scales in measures of self esteem and overall adjustment (Gilbert, 1981; Kelly & Worell, 1977), and were rated as behaviorally ineffective and incompetent in situations requiring them to act in stereotypically masculine or feminine roles (Kelly et al., 1981; Kelly et al., cited in Kelly & Worell, 1977). Some studies have found that Undifferentiated individuals have the capacity to overcome initial deficits of skill level through counseling skills training (Fong & Borders, 1985; Fong et al., 1986), but these studies also supported the finding that at least initially, these individuals are less effective in their ability to demonstrate counseling skills than either the Androgynous or Feminine sex role orientations. The Masculine group was found to be lower than any others in these studies. The cross-sex typed individuals have rarely been analyzed independently of Masculine typed and Feminine typed groups, as they are commonly included as part of these groups rather than examined separately from them. This will be true in this study as well, although these constructs will be consider-
These observations suggest implications for therapists in terms of the therapeutic relationship. Therapists are required to assume some flexibility in the roles which they take with clients in order to provide a therapeutic context for change to be possible. This is true regardless of theoretical orientation, as Gelso and Carter (1985) have pointed out, since all therapy consists of doing something either with, or for the client. Some clients' presentations will require that therapists behave in ways that may not be within their sex typed repertoire of behaviors or are inconsistent with their internalized sex role orientation. Theoretically, when this occurs it is likely to be more difficult for the sex typed (Masculine or Feminine), or the Undifferentiated therapist to respond in therapeutically appropriate ways (with empathy, warmth, genuineness, concreteness, self-disclosure, confrontation, advanced empathy, and immediacy) than for the therapist who is more Androgynous. Fong and Borders (1985) demonstrated this in their study of beginning counselors' general counseling skills. It seems to follow that the therapist would perhaps experience increased anxiety and defensiveness when confronted with the inherent need in the therapeutic endeavor for flexibility (Currant, et al., 1979) and that this internal experience constitutes countertransference. It also follows that the
internal experience of countertransference increases the probability of accompanying countertransference behaviors (Bandura, 1956; Milliken & Kirchner, 1971; Yulis & Kiesler, 1968), as may be evidenced by the therapist's withdrawal of involvement in the therapeutic situation (Bandura, 1956; Heller et al., 1963; Milliken & Kirchner, 1971; Peabody & Gelso, 1982; Robbins & Jolkovski, 1987; Strupp, 1958; Yulis & Kiesler, 1968). Consistent with these propositions, and as suggested by the work of Donner and Schonfield (1975), Russell and Snyder (1963), Peabody and Gelso (1982), and Howard et al., (1969), the type of client presentation may be expected to elicit a differential countertransference effect in the sex typed (Masculine and Feminine) individuals. Because of the narrower range of responsive behaviors, and because of the specific ways in which they organize the stimulus features of their worlds according to their sex role orientation, it would be expected that these individuals would vary more in their levels of countertransference behaviors than Androgynous or Undifferentiated individuals. The Androgynous individual would be expected to have consistently less countertransference behaviors, since for this person there is a wider range of responses from which to choose, including both masculine and feminine characteristics. For the Undifferentiated individual there is less of a range, but it would be expected that these persons would be
consistently higher in countertransference behaviors than the Androgynous individual. The Masculine and Feminine sex role orientations, however, would be expected to have greater variety in levels of countertransference responses between clients, especially when the clients to whom they were responding represented differing kinds of presentations. The ability to respond consistently to differing client types would, therefore, be less likely in individuals with Masculine and Feminine sex role orientations than those with Androgynous or Undifferentiated orientations.

Hypotheses

It is proposed that sex role orientation is related to the therapist's countertransference behaviors. If it can be shown that the sex role orientation of the therapist (measured by the Bem Sex Role Inventory) is related to the levels of countertransference behaviors which are exhibited (measured by a procedure assessing withdrawal of therapist involvement), then it may be assumed that a relationship exists between these variables. Therapists who have Masculine and Feminine sex role orientations will be more likely to behave countertransferentially than those in the Androgynous classification due to the limited range of behaviors, as well as the particular preconceived sets which they bring to the therapy relationship. In
consideration of previous studies (Buczek, 1981, 1986; Fong & Borders, 1985; Fong et al., 1986; Jourard, 1971), it is expected that persons with Masculine sex role orientation will exhibit more countertransference behavior than any other group. It is also proposed that individuals in the Undifferentiated classification will exhibit more countertransference behavior than the Androgynous individuals, since they have less adaptive behaviors in their interactional repertoire. Conversely, therapists with Androgynous sex role orientation will exhibit less countertransference behavior than other sex role orientations because of their relative flexibility in the therapeutic relationship. The therapists whose sex role orientations are Masculine and Feminine are expected to demonstrate countertransference behaviors that vary significantly according to type of client presentation that is being experienced, since the stimulus value of varying presentations has been shown to elicit differential levels of countertransference responses (Robbins & Jolkovski, 1987). However, the differences in levels of countertransference behavior by type of client presentation are expected to be insignificant in the Androgynous and Undifferentiated groups, while significant differences are expected in Masculine and Feminine orientations. This is expected because of the broader range of interpersonal skills that have been observed in the Androgynous individuals, and the
more limited range of interpersonal skills observed in Undifferentiated individuals (Fong & Borders, 1985; Fong et al., 1986; Gilbert, 1981; Kelly & Worell, 1977). While the overall levels of countertransference behaviors should be greater in the Undifferentiated group than the Androgynous group, neither of these groups should exhibit significant differences between client presentation, as is expected to occur in Masculine and Feminine groups. This expectation is due to findings that sex typed individuals have less adaptive styles, and are more prone to exhibit competency in some situations while they are less competent in other situations (Kelly et al., 1981; Kelly et al., cited in Kelly and Worell, 1977).

Definitions

Countertransference

The totalistic view consistent with Kernberg (1965) will be used, where all therapist attitudes and behaviors toward the client, both conscious and unconscious, are considered to be countertransference.

Countertransference behavior

This refers to those therapist behaviors which occur
in the therapeutic relationship, either resulting from reaction to the client's presentation, or from the conscious or unconscious dynamics that the therapist brings to the relationship. Operationally defined, countertransference behaviors are those which represent withdrawal of personal involvement from the therapeutic process, consistent with definitions from several previous studies (Bandura, 1956; Cutler, 1958; Heller et al., 1963; Peabody & Gelso, 1982; Robbins & Jolkovski, 1987; Strupp, 1958; Yulis and Kiesler, 1968). Withdrawal of involvement is primarily considered to be a negative form of countertransference for the purposes of this study.

Sex role orientation

Consistent with Bem (1974) and Spence et al., (1975), this is an individual's self endorsement of traits and characteristics that classify him or her as stereotypically Masculine, Feminine, Androgynous or Undifferentiated.

Androgynous

The classification assigned to an individual, regardless of gender, whose endorsement of traits is significantly high for both stereotypically Masculine and Feminine characteristics.
Feminine

The classification assigned to an individual, regardless of gender, whose endorsement of traits is significantly high for stereotypically Feminine characteristics.

Masculine

The classification assigned to an individual, regardless of gender, whose endorsement of traits is significantly high for stereotypically Masculine characteristics.

Undifferentiated

The classification assigned to an individual, regardless of gender, whose endorsement of traits is not significantly high in either Masculine or Feminine stereotyped characteristics.

Limitations

The researcher is aware that this study only measures one aspect of countertransference, and that a much broader consideration must be given to the subject. As previously stated, to operationally define something, one necessarily imposes limitations that may narrow the subject to the point of being clinically and practically restricted. This study, using the operational definition and methods stated, will examine an aspect of countertransference that
other researchers have found to be useful, primarily withdrawal of involvement. While this is a limitation of the study, since operationally defining countertransference in this way narrows it to an overt behavior, as well as to only one aspect of a very broad and complex subject, this limitation can also be viewed as a potential strength of the study.

The author is also aware that the construct used to measure countertransference behavior, therapist withdrawal of involvement, may not always be viewed as a behavior related to countertransference, but can also be an appropriate and legitimate therapeutic choice in working with some clients in given situations. It is hoped that in approaching withdrawal of involvement as a negative aspect of countertransference in this study, that a contribution can be made which will eventually lead to a meta-analysis of countertransference.

To examine a complex subject thoroughly, it is necessary to explore manageable parts of that subject. That is the approach that this study takes. By examining the subject as it has been defined, one very important aspect of the broader subject of countertransference may be better understood.
CHAPTER II

REVIEW OF THE SELECTED LITERATURE

Countertransference

Countertransference is a phenomenon that has been observed and scrutinized by psychoanalysts and therapists for many years. Since the time Freud (1910/1964) first recognized and wrote about it, theorists and clinicians have written about the occurrence of countertransference in the therapeutic endeavor. The result has been a substantial quantity of literature which has evolved through clinical experience, but until the 1950s very little empirical investigation of countertransference had been done.

Epstein and Feiner (1979) have observed that during the late forties and early fifties significant changes were taking place in the psychoanalytic community. Challenges were being made on many of the traditional positions in psychoanalysis, including understandings and definition of countertransference. This was the result, as pointed out by Epstein and Feiner (1979), of Freud's own ambiguity and tentativeness in addressing this issue. Consequently, plenty of latitude existed for varying
interpretations on the subject, and several writers began to call for a broadened view of countertransference (Heimann, 1950; Little, 1951; Racker, 1968). In his original mention of the subject, Freud (1910/1964) suggested that countertransference occurred, "as a result of the patient's influence on his [the physician's] unconscious feelings" (pp. 144-145). The classical position asserted that countertransference was the result of the analyst's unconscious resistive reactions to the patient's transference, was undesirable for effective therapy, and should be overcome. Singer and Luborsky (1977) held Reich's (1951) paper as the definitive statement representing this position.

The broadened, more totalistic theoretical view of countertransference has evolved from the classical position, and proposes that all attitudes, feelings and behaviors that the therapist has toward the patient should be considered to be countertransference (Epstein & Feiner, 1979). Racker (1968) proposed that both direct and indirect qualities of countertransference existed; direct being those therapist feelings and behaviors that occur in response to the relationship with the patient, and indirect being the therapist's attitudes and values which, in effect, predispose one to countertransference. Racker's proposal has gained broad acceptance (Singer & Luborsky, 1977), and has contributed to a wider, more encompassing
definition of what constitutes this phenomenon. The broadened definition of countertransference has led persons from other theoretical orientations within psychology to more carefully examine this phenomenon, to the benefit of the entire profession (Gelso & Carter, 1985). This more expansive understanding of countertransference has provided a broader field for empirical investigation and analysis. Much of the literature that is reviewed here has grown from this widened theoretical perspective.

Empirical Studies of Countertransference

The empirical literature on countertransference began to emerge after the Second World War. Its evolution coincided with an increasing emphasis on quantification in the field of psychology (Leahey, 1987). However, even during this period, very few quantitative investigations were conducted, probably because those interested in the subject were more concerned with defining and theorizing about what countertransference was than with its empirical study.

In a review of the status of clinical and quantitative literature, Singer and Luborsky (1977) suggested that one of the first attempts to systematically study the presence of countertransference in clinical settings was part of the Menninger Foundation's Psychotherapy Project. After the treatment phase had concluded in this project,
attempts were made to quantify the results. Emerging from that attempt was an evaluation of the extent to which countertransference had affected the therapy process in the study. Luborsky, Fabian, Hall, Ticho, and Ticho (1958) examined process notes as well as post-therapy interviews with therapists, clients and supervisors, but still could not determine the influence of countertransference in the work. Although this effort to explore countertransference was of limited usefulness, probably because the design was constructed after the data had been collected, it does seem to have pointed others in the direction of empirical study of the subject.

Fiedler (1951) made attempts to systematically quantify countertransference. His work focused on an elaborate systemization of therapist feelings and perceptions using the assumption that countertransference involved the unrealistic feelings and perceptions in the relationship with the patient. Therapists and patients described themselves by sorting 76 statements into eight categories, ranking them from most to least descriptive of themselves. Therapists were also asked to present how they would ideally describe themselves, and how they thought the patients would describe themselves. The sortings were then analyzed and four variables emerged that indicated those situations in which therapists were more likely to experience misperceptions. Fiedler proposed that when the...
therapist assumed that the client was more similar to his own self perception than was true, empathic conditions would result. Less similarity would mean less empathy. Likewise, it was proposed that when the patient was seen as being closer to the therapist's own ideal, more demands and expectations would be placed on the client. With greater disparity, the therapist was more likely to offer support. The last step for Fiedler was to obtain competence ratings from a very experienced supervisor. His results showed that the more competent therapists had higher levels of what he had determined to represent empathy and liking, and were also more supportive and less demanding. A critique of Fiedler's study by Singer and Luborsky (1977) suggested that there are some problems in the assumptions and generalizations made in the study regarding the structuring of the categories, and this criticism appears to be warranted. Nevertheless, his work does suggest that a systemization of clinically relevant categories of countertransference is possible.

Several studies have productively examined the presence of hostility conflicts in therapists and their relationship to countertransference responses. Bandura (1956) focused his study on the effects experienced by therapists who have difficulties handling their own hostility as they encounter patients expressing hostility. He proposed that if patients express hostility, whether it is a
transference phenomenon or not, the therapist who has conflicts in this area will respond with increased avoidance behavior in order to minimize his or her own experience of anxiety. The 12 therapists, all of whom were graduate students, were rated on a scale assessing anxiety in relation to conflict by four clinical psychology staff members who knew them. The therapists were also rated according to the extent to which they responded to conflict with others by a direct or indirect expression of their hostility. Finally, they were rated on their need for approval and dependency. Tape recordings of therapy sessions were analyzed for content of hostility by the patient and the type of responses made by the therapist, with special attention to the therapist's approach or avoidance responses. The therapists were divided into groups of high and low scorers on the scales of dependency, hostility, and approval ratings, and also on the ratio of approach to avoidance responses in the therapy sessions. The data analysis showed that those therapists who tended to express their hostility directly and had low need for approval were less likely to respond to patient hostility with avoidance responses, and more likely to respond with approach responses. The study also revealed that therapists were more likely to make avoidance responses when the patient's anger was directed toward them than when it was directed at others.
Closely related to Bandura's work is an extensive study by Cutler (1958), in which he examined therapist personality characteristics and conflict areas and the manifestation of countertransference in therapy. The results supported the notion that when countertransference is encountered, it is likely to result in therapist distortions, as well as create obstacles to the therapeutic process. Two therapists completed self rating scales in order to evaluate 16 interpersonal behavior categories of their personalities. Nine or more judges who knew the therapists well also rated them using the same rating scales. By assessing the ratings on the personality variables in which significant discrepancies were found, Cutler identified areas which he proposed to be representative of conflict. Those areas in which ratings of therapists and judges were not significantly different were determined to represent a lack of conflict. Tapes of therapy sessions were scored by judges according to the occurrence of behaviors indicative of the 16 personality variables, with the assumption being that this represented an objective account of what had actually occurred during the session. The therapists made detailed accounts of what happened in each session and these were also scored according to the personality variables. A final measure involved the scoring of therapists' in-session interventions according to effectiveness, in terms of facilitating
the patient's discussion of relevant material. The results revealed that therapists were less accurate in reporting their own, as well as their patient's, behavior in those situations where the topics were related to their own conflict areas. It was also found that when the therapist was working with a patient in an area that represented conflict for him, he was judged to be significantly less effective than when working with more neutral material.

Milliken and Kirchner (1971) examined the therapeutic effectiveness of highly anxious counselors when confronted with client feelings. The counselors conducted interviews with actor-clients who were expressing different emotions. The counselors also were assessed for anxiety using the Anxiety Scale Questionnaire. It was found that counselors who scored higher on the anxiety scale were more defensive, as measured by the difficulty they had in recalling what had occurred in the interview. This appears to represent countertransference behavior in the form of defensive avoidance, similar to that proposed by Cutler (1958). Yulis and Kiesler (1968) found in their analogue study of countertransference and anxiety that therapists rated with higher anxiety exhibited significantly more defensiveness in their therapeutic responses, which was interpreted as countertransference. The sample consisted of 24 graduate students in psychology who were divided into two groups.
based on ratings of anxiety according to an anxiety scale developed by Gleser, Gottschalk, and Springer (1961). The two groups of high and low chronically anxious subjects then listened to three tape recordings of actor-clients who represented aggressive, sexual or neutral clients. At designated spots the subjects were directed to select one of a pair of responses that best represented how they would respond to that client in therapy. The study does seem to suggest that therapists with higher levels of anxiety in general will be more prone to engage in countertransference behavior. Conversely, therapists with lower anxiety will be more likely to engage therapeutically with patients demonstrating transference behavior.

In a related study, Donner and Schonfield (1975) found that student therapists with less conflict responded with lower levels of anxiety to patients who made depressive statements. The student therapists who had higher conflict levels responded with more anxiety to their depressive patients. The authors offered the proposal that therapists who are more conflicted may be subject to greater levels of countertransference, as indicated by Yulis and Kiesler (1968), especially in response to specific patient characteristics.

Russell and Snyder (1963) studied therapists' countertransference by examining the physiological responses of therapist anxiety, in addition to judges' ratings of
anxiety. In their study, 20 graduate students were divided into two groups of 10 each, with groups representing high and low experience level as therapists. Interviews were then conducted with two actor-clients who were to present in either a hostile or friendly manner. The therapists' anxiety was measured by judges' observations of therapist behavior through a two way mirror by number of eye blinks, as well as by palmar sweating. The level of therapist experience was not a significant factor in the level of anxiety measured in this way, but it was found that the therapists were significantly more anxious with the hostile client. This study represents a more behavioral approach to research in countertransference, although illuminating in that observation of the therapists' physical reactions was obviously also available to the clients.

Most of the preceding studies seem to represent those that have considered the more unconscious processes involved in countertransference. Each attempted to empirically examine the internal experience of the therapist's countertransference responses. The following studies represent those which appear to take another step away from the classical view of countertransference. These authors explored variables which, although they included aspects of the therapist's unconscious processes, at times are more pertinent to conscious experience. These studies
incorporated aspects of therapist self awareness as a part of the examination of countertransference. They also represent movement toward a more totalistic view of countertransference, and provide rich information regarding the occurrence and nature of such phenomena.

Peabody and Gelso (1982) utilized some of the same concepts as Yulis and Kiesler (1968) in examining the interaction of empathic ability to countertransference behavior and countertransference feelings in 20 male counselor trainees. In their study, empathy was found to be negatively related to countertransference behavior with seductive female clients, but not with neutral and hostile clients. The authors found in their subjects' responses to clients on audio tapes (the same used by Yulis & Kiesler in their 1968 study), that with the seductive presentation, the more empathic the subject was, the less countertransference behavior, although with hostile and neutral clients the subject's level of empathy was not so important. Another finding indicated that the counselor's empathic ability related positively to counselor reports of openness to countertransference feelings. The more open to countertransference feelings a counselor was, the more likely he would be to respond to the client in an empathic way. It was suggested, however, that there was a limit to how often countertransference feelings could be experienced in a session before an increase in counter-
transference behaviors would begin to significantly increase.

In a study that built upon Peabody and Gelso's (1982) work, Robbins and Jolkovski (1987) explored the interaction of the relationships between countertransference (understood to be withdrawal of involvement as in previous studies), therapist's awareness of feelings, and the extent to which a theoretical framework is used. Fifty-eight graduate doctoral students were assessed on their levels of countertransference feelings and theoretical framework. They were then given instructions to listen to two audio tapes of client-actresses who presented themselves in either neutral or sexual roles. In fact, the two tapes were from Yulis and Kiesler's (1968) study on countertransference, and the same procedure was followed in having the therapists respond at given intervals as they would if they were therapist with these clients. Several significant interactions were found by the authors. The same effects reported by Peabody and Gelso (1982) were replicated with regard to the therapist's awareness; the more aware of their own feelings, the more they will remain engaged in the therapeutic interaction and not engage in responses indicative of countertransference. They also suggested that the results supported the notion that therapists who have higher levels of theoretical framework, regardless of what that framework may be,
are more aware of their own feelings and would be less likely to engage in behaviors indicative of countertransference.

Howard et al. (1969) attempted to make a systematic investigation of the therapist's feelings in the therapy session and how those feelings relate to the patient's feelings and behavior. They devised a Therapy Session Report (TRS), which was determined to reflect the perceptions of participants in the therapeutic relationship, topics discussed, feelings experienced, and the process that took place in the therapy session. The TRS consisted of 167 patient items and 168 therapist items, and both therapist and client completed the instrument after each therapy session. Using 19 male and female therapists and 60 female patients, they found 28 cases where both therapist and client had completed at least eight forms, and using these as their sample, they analyzed the data. Nine therapist dimensions and 11 patient dimensions merged from their multivariate factor analysis, and correlations were computed for significant relationships. The most significant findings were related to therapist sex differences. Male therapists exhibited a significant tendency to feel uncomfortable when their female patients experienced erotic transference resistance (embarrassing sexual feelings), whereas female therapists responded more neutrally to the same patient feelings. When the therapists were tense and
embarrassed and the patient expressed intrusive demands, it was the female therapists who exhibited more significant discomfort, but the male therapists exhibited more neutral responses. This may be suggestive of countertransference as a factor of sex role socialization.

Therapist Attitudes as Countertransference

Another step away from the classical understanding of countertransference is represented by several studies exploring therapist attitudes toward the client. A more totalistic view is represented by most of these endeavors, as therapists' more conscious processes have been explored in their attitudes and behaviors. This in no way minimizes the contribution of these studies to the empirical understanding of countertransference; in fact, they are quite informative and insightful.

One such study was undertaken by Strupp (1958), who explored the extent to which the therapist's attitudes and personality influenced behavior in diagnosis and treatment. A film of a patient in an initial interview was shown to 134 therapists, some more experienced than others. At various pertinent spots the film was stopped and therapists recorded how they would respond if they were this patient's therapist. After the film, therapists completed questions regarding diagnosis, treatment, potential problems and attitudes toward the patient. A
significant relationship was found between prognosis and attitude, in that therapists indicating dislike for the patient gave harsher diagnostic labels than those therapists indicating more positive attitudes. Therapists who disliked the patient also tended to see the patient as more immature, less insightful, and having a poor prognosis. They expected to have more problems with countertransference reactions, and tended to favor approaches that were more strict, brief and active. Strupp rated their interventions as colder and less empathic. Therapists who expressed positive attitudes gave the patient a better prognosis, suggested more permissive and passive interventions, and chose longer term therapy approaches. They were rated as more empathic and warm, and although they anticipated countertransference, they believed that they could deal with it effectively. Strupp also found that the group indicating dislike had responded with interventions rated as cold three times more often than the group with positive attitudes. He noted that when therapists who had undergone their own analysis indicated dislike for the patient, they made significantly more empathic interventions than unanalyzed therapists who disliked the patient.

Two relatively recent dissertations offered suggestions on therapist feeling and attitude toward the client. Schlesinger (1984) studied the effects of a self analytic
exercise on clinical judgement, having two groups listen to a tape of a hostile patient and make ratings about liking, empathy, prognosis, and treatability. Both groups were then involved in processing the experience, with one group instructed to focus on descriptive aspects of the patient and the other group directed to focus on their feelings, thoughts and fantasies about the client. Next they listened again to the tape, and again rated the client. The results showed that the self analytic group reported more empathy and positive feelings for the client. McClure (1984) collected data from 12 therapists and their 37 patients, including assessments of both patient and therapist personality factors, and therapists' perceptions of their patients' personalities. Significant results were reported in the relationship between therapists' strong feelings of liking or disliking their patients and countertransference. This may be as much a phenomenological inference as an empirically substantiated finding. McClure suggested that the therapist's attitude toward the patient may have been the activating factor for countertransference, rather than the therapist's conflict areas.

Freemont and Anderson (1988) investigated some of the factors involved in therapists' annoyance with clients, suggesting that certain client behaviors elicit more consciously experienced annoyance and anger in therapists. The two most significant annoyance factors were when the
client made impositions on therapist's time, or engaged in personal attacks on the therapist. The latter was also supported by Bandura's (1956) work, as well as that of Gaminsky and Fairwell (1966). One-hundred-one therapists from 13 agencies completed a 16 item questionnaire describing their reactions to the behaviors of three irritating or annoying clients (determined from a previous study by one of the authors). The results were then analyzed to determine what factors were most likely to correlate with therapists' own predictions about what situations they would find most annoying and irritating. The authors noted that therapists were less likely to report irritation with clients in response to resistance and client dynamics, concepts that are somewhat ambiguous but seem to refer to more transferential notions. Therapists did indicate more irritation with clients who made demands on the therapist's time, either by requesting special accommodations or making emergency appointments and then not keeping them. More irritation was also reported in response to direct attacks on the therapist. In their discussion, the authors suggested that the issues which elicited more therapist annoyance could be characterized as boundary issues, and as such are less clearly defined and more ambiguous in terms of the therapist's "rules" about what constitutes therapy. The therapists may have expected more client resistance as part of the
therapeutic task, but experienced more irritation when
required to work with clients who pushed them into areas
that violated their understanding of what was appropriate
for a patient to do and ask.

Countertransference and Therapist Level of Experience

Several studies have explored the relationship of the
therapist's level of experience to countertransference.
Strupp's (1958) work suggested that more advanced thera­
pists (those who had undergone their own analysis) were
less likely to respond with countertransference behavior
when they disliked the client. In another study by
Heising and Beckman (1971) (cited in Singer & Luborsky,
1977), the authors reported their assessment that diag­
nostic and prognostic interference distortions occurred
based on the therapist's personality characteristics and
level of training.

A study which attempted to differentiate experienced
from inexperienced therapists was conducted by Beery
(1970). A tape of an actor-client taking either a friend­
ly or hostile role was presented to both experienced and
inexperienced therapists. The therapists were asked to
respond to the presentation in the manner in which they
would if this was their patient, and their responses were
recorded. Responses were rated on the dimensions of
warmth-acceptance versus hostility-rejection. Most thera­
pists, regardless of their level of experience, responded more positively to the friendly patient than they did to the hostile one. However, the group of more experienced therapists tended to respond more positively than inexperienced therapists to both friendly and hostile clients. While both groups seemed to be responsive to hostile versus friendly patient presentation, the experienced therapists exhibited less of what could be called countertransference behaviors. The question of why this occurred was not addressed in this study.

A dissertation by Harmell (1988) supported a differentiation between levels of therapist experience. Data collected from 113 practicing clinicians with Ph.D.'s included assessments of countertransference and self awareness (FIRO-B and supplement), level of experience, and theoretical orientation. Correlation analyses indicated that significant relationships existed between level of experience and detachment from the patient, with less experienced therapists experiencing more unpleasant feeling and detachment from their clients. Overall, more experienced therapists displayed less countertransference in areas measured by Harmell's constructs than that exhibited by less experienced therapists. Exploration of theoretical orientation indicated psychoanalytic therapists had less countertransference than other orientations. Even though this study considered only conscious behavior
through self report in determining level of countertransference, it did substantiate that less experienced therapists at least made more report of such experiences.

Another dissertation that examined the conscious countertransference reactions by beginning therapists to patient anger was written by Torres (1984). Interviews were conducted using a specially developed countertransference interview to assess affective reactions of fear, confusion and anger in response to overt and covert patient anger. The subjects were 40 third-year doctoral students in clinical psychology. Analysis of the data suggested that beginning therapists uncomfortable with the expression of anger in their own lives were also more uncomfortable with overt patient anger, and tended to view these kinds of patients as more aggressive than therapists who did not experience such conflict with their own anger.

Sex Role Orientation and Gender

With respect to countertransference, little research has been conducted regarding therapist gender, and none related to sex role orientation. The literature indicates that therapists' attitudes, values and behaviors have been examined in relation to sex role orientation and gender, but the focus has never been specifically with behaviors related to countertransference.
Theoretical Concepts

Professional interest in sex role orientation has vacillated over the years, perhaps coinciding with cultural movements and influences (Leahey, 1987). The most prolific exploration of this area has occurred since Bem (1974), Constantinople (1973), and Spence et al., (1975) proposed new ways of conceptualizing sex roles and sex typing. Prior to these new formulations, masculinity and femininity had been considered as opposites on a bi-polar continuum, an approach that led to significant difficulties in the definition and understanding of sex differences. Some earlier writers recognized the need for alternative conceptualizations, such as Parsons and Bales (1955) and Johnson (1963), who asserted that masculinity reflects cognitive instrumentality and goal directedness, whereas femininity reflects more affective, expressive, and supportive responses. These early proposals provided a context for later developments in sex role orientation.

Constantinople (1973) was one of the first to critique traditional measurement of sex role characteristics, pointing out that in this bipolar understanding the presence of masculine traits automatically meant the absence of feminine ones. She elaborated on the lack of theoretical and empirical bases that such an approach represented and suggested revision of these inadequate constructs.
Bem (1974, 1981a) has made significant contributions to theoretical and empirical understandings in sex role orientation. In her conceptualization she proposed that individuals have a Masculine, Feminine, or Androgynous sex role orientation. The Masculine and Feminine orientations are not seen as bipolar aspects of a single continuum of sex role identity, as had previously been proposed, but as independent dimensions. The Masculine sex role orientation reflects more instrumental roles that are associated with task-orientation, goal-directedness, and independence, as had been proposed by others (Johnson, 1963; Parsons & Bales, 1955). The Feminine sex role is representative of more expressive roles, such as nurturance and receptivity, and is represented by traits that are affective, supportive, and focused toward others. Since these orientations are separate dimensions, individuals may endorse traits that are indicative of either orientation, allowing for greater accommodation and flexibility in understanding levels of sex role identity. When individuals endorse proportionally more characteristics which are consistent with their own gender than the opposite gender, they are considered to be sex-typed. An endorsement of a higher proportion of characteristics that are of the opposite sex results in a cross sex categorization, which is typically not differentiated from Masculine or Feminine categories. The Androgynous sex role orientation repre-
sents an integration of both Masculine and Feminine qualities, resulting in an individual with capacities in both sex role dimensions.

This conceptualization has resulted in a very productive theoretical framework, and an instrument which measured these constructs called the Bem Sex Role Inventory (BSRI) was developed and eventually published (Bem, 1981a). Bem's (1974) original proposal of this instrument allowed for classification of levels of stereotypical masculine and feminine characteristics, resulting in persons with sex orientations of Masculine (high masculine, low feminine endorsement) and Feminine (high feminine, low masculine endorsement). Later theoretical and research considerations (Bem, 1977; Spence et al., 1975) resulted in the addition of two additional sex role orientation categories: Androgynous (high masculine and high feminine endorsement) and Undifferentiated (low masculine, low feminine endorsement). This inclusion has added to the conceptual framework originally proposed by Bem (1974), and has facilitated considerable empirical research on sex role orientation, as suggested by Lippa's (1985) observation that more than 400 studies had been reported in 1984 which incorporated Bem's (1981a) instrument. Other instruments have been developed by Spence et al., (1975), Heilbrun (1976), and Berzins, Welling, and Wetter (1978) to assess sex role orientation. These instruments
represent slightly different approaches to the measurement of sex role socialization, but the conceptualizations are primarily the same. Nevertheless, the BSRI continues to be the most widely used measure of sex role orientation.

Bem (1981b) has continued to develop her theoretical conceptions of sex role processes by proposing that the differences observed in sex role orientation may represent nuances in cognitive processing by gender schema. She suggested that, at least in part, sex typing occurs as a result of gender based schematic processing, with individuals perceiving and processing all incoming stimuli through a cognitive schema that has been socialized according to stereotypical sex roles. She cited several studies which supported her contentions, and proposed that more investigation be done in this area.

Attitudes and Behaviors

Studies have been conducted which examined the presence of counselor attitudes that influence what occurs in the therapeutic relationship. Therapists' attitudes have been explored in relation to their behaviors, and relationships have been observed that support the notion that attitudes related to sex role orientation do influence the therapeutic interaction. Wampold, Casas, and Atkinson (1981) reported that their findings demonstrated that counselors' stereotyping interfered with their processing
of information with ethnic minority clients. Casas, Brady, and Ponterotto (1983) reported similar interference in response to homosexual individuals. In studies that explored the conceptual development of the counselor, it has been shown that higher levels of conceptual development are associated with greater demonstration of empathy (Brown & Smith, 1984), and more effective performance in a range of counseling behaviors (Fuqua, Johnson, Anderson, & Newman, 1984).

Counselor empathy has been examined in studies with student counselors. When such research has been conducted on demonstration of empathy in relation to gender alone, the results have typically been inconclusive (Hoffman, 1977; Petro & Hansen, 1977). Exceptions to this have been reported by Abramowitz, Abramowitz, and Weitz (1976) and Kimberlin and Friesen (1980), who used a similar procedure in finding that female counseling students were significantly more empathic than male students after they had all received training in empathy skills. However, when studied in the context of sex role orientation, it has been observed that interesting differences do exist. Carlozzi and Hurlburt (1982) examined the relationship of sex role orientation with empathy in graduate counseling students. They found that expressiveness (associated with feminine sex type) and empathy had a moderate positive correlation. They had hypothesized that instrumentality (associated
with the masculine sex type) would be negatively correlated with empathy, but did not find this to be true. While no differences existed between gender in relation to empathy, it was found that endorsement of feminine traits related to empathy, while endorsement of masculine traits had no relationship with empathy. The undifferentiated and androgynous classifications were not used in this research.

In studies of sex biases in counseling situations, Buczek (1981, 1986) found that the gender of the counselor was related to the amount of recall ability about the person being interviewed. In her earlier study with 89 clinical psychology doctoral students, Buczek (1981) reported that female counselors had greater ability to recall client information in a post-interview evaluation than male counselors, but that both male and female counselors were less effective at recalling concerns of female clients than they were at recalling information presented by male clients. She also reported that male counselors asked female clients more questions related to family relationships and social functioning than they asked male clients. Female therapists did not similarly attend to these areas with female clients, suggesting some bias in male counselors according to sex role stereotype. In her later study (Buczek, 1986), she compared those results with data collected from 218 undergraduate students (116 males, 102 fe-
males) using the same procedure. Again, female client information and concerns were less frequently recalled than were concerns of male clients by all subjects. Previous findings were also duplicated regarding female subjects recalling more overall client facts than male counterparts, but males and females both asked many more questions of a domestic-social nature than in the previous study. These findings indicated some evidence of sex biases of therapists, especially related to the therapist's gender, but it may be useful and informative to examine these differences in light of sex role orientation, as this could provide further illumination of the issue.

One of the interesting findings regarding the differences observed in sex role orientation has been reported in research that has considered sex role orientation and the acquisition of counselor training skills. Fong and Borders (1985) conducted a study to determine the effect of sex role orientation and gender on skills training. Forty-seven counselor education students were classified using the BSRI, and were asked to make two tapes of their responses demonstrating specific counseling skills, one tape at the beginning of a course in counseling skills, and one at the end. In the first tape, persons in the Androgynous classification scored highest in demonstrating appropriate skills; Feminine and Undifferentiated ori-
tations were very closely grouped and those in the Masculine orientation were significantly lower, similar to previous observation (Anderson & Bem, 1981; Kelly et al., 1981). After the training had occurred and the second tape was made, the Androgynous group showed moderate increases in counseling skills, but all other groups improved significantly, with the Undifferentiated group improving most. The results also showed that the Masculine group remained the lowest overall in demonstrating effective counseling skills. The most surprising finding was that the Undifferentiated group had the highest overall rating of counseling skills at the end of the study, a finding that the authors suggested required further investigation. The results of this investigation seemed to indicate that certain sex role orientation classifications may exhibit less proficiency in the therapeutic endeavor, but that steps can be taken to minimize the negative effects through training. An aspect that was not assessed in this study was whether the skills training had any effect on the sex role orientation of the counselor, since it is conceivable that the acquisition of a broader repertoire of behaviors may also alter the classification in which these individuals were originally placed.

A similar study was conducted by Fong and associates (1986) which examined the effects of sex role orientation and level of self disclosure flexibility of 44 counseling
students on demonstration of counseling skills and overall effectiveness during and after counseling skills training. Subjects were classified according to the BSRI, measured by their levels of self disclosure flexibility, and were assessed on counseling skills during and after a training course. On the initial assessment, Androgynous counselors were highest in their self disclosures and overall effectiveness while Masculine counselors were lowest. In the final assessment, the Feminine and Undifferentiated counselors were rated highest, with the Androgynous counselors showing only moderate improvement from their initial ratings, and the Masculine subjects showing good improvement but continuing to be least self-disclosive and effective. As in the previously cited study by Fong and Borders (1985), improvement was facilitated through training in counseling skills, but how this training may have affected the individual's classification of sex role orientation was not addressed.

Several studies have been conducted that demonstrate that the counselor's sex role orientation and gender are related to attitudes and behaviors toward the client. Lippa (1977) suggested that the sex typed counselor (males with Masculine sex role orientations and females with Feminine sex role orientations) may be more sensitive to the client's own masculinity and femininity cues than others. Werrbach and Gilbert (1987) propose that therapists ap-
proach male clients with very circumscribed stereotypes that result in unique distortions in the therapeutic relationship. Gilbert (1987) offers that male therapists, in general, are more likely to have less awareness about their own dependency needs, resulting in increased behavioral acting out in therapy, especially toward women.

Related Studies

In a study that examined androgynous views in male and female mental health professionals, Thomas (1985) reported that of the 116 psychiatrists and psychologists who responded to her questionnaire, male and female subjects were not significantly different in their stereotyping attitudes of female patients, and both genders represented androgynous mental health perspectives. The author maintained that these findings suggested that the age of androgyny has arrived. However, Thomas does not account for the self selection process that occurred, since only 116 of her original 196 subjects responded to her survey. She reported that her findings contradicted 15 studies conducted which had supported the presence of therapist stereotyping (Sherman, 1980, cited in Thomas, 1985). However, there were also studies during this time that demonstrated that stereotyping was not as commonly observed as expected (Maxfield, 1976). There does seem to be support for a shifting view in stereotypical behaviors by therapists,
but how this is different from the overall cultural shift in attitudes is undetermined.

Jourard (1971) reported from his examination of the research that the most consistent variable related to self disclosure was gender. He found that males were typically less disclosive than females in the studies he considered. Females were observed to be more disclosive, and were likely to receive more disclosure from people with whom they interacted than males. These findings should be considered in light of the historical context from which they were observed, since much change in awareness of sex roles has occurred in the last 20 years.

In an analogue study of self disclosure and sex role orientation in college students, Stokes, Childs, and Fuehrer (1981) reported that gender was not related to self disclosure in this population, but that examination of sex role orientation did yield significant differences. Only Androgynous subjects were willing to disclose to intimates, and they were found to be the group that was most willing to disclose of any orientation. This is consistent with previous conclusions suggesting that the Androgynous individual is more flexible than those in other sex role orientations (Wiggins & Holzmuller, 1978, 1981).

Two studies which are similar to each other involve undergraduates involved in role plays of social-interpersonal situations which required either a warm, complimen-
tary response or a direct rejection of unreasonable demands (Kelly et al., 1981; Kelly et al., cited in Kelly & Worell, 1977). In both studies the Androgynous subjects were rated as more effective in their responses than other sex role orientations. The conclusions in these studies suggested that androgyny, the combination of both masculine and feminine traits, was essential in functioning effectively in complex social interpersonal situations. It was also observed that individuals in the Undifferentiated classification were the least effective in most of the variables measured, indicating less interpersonal competence.

Another analogue study involved 160 college students (80 males, 80 females) who anticipated anxiety and projected responses to a variety of videotaped presentations (Currant et al., 1979). Students who had been categorized as either Masculine, Feminine, or Androgynous were to view tapes of actors portraying situations in which they made either oppositional or expressive assertions. They were to rate the probability of their making such assertions and their anticipated anxiety if they did so. Feminine typed subjects expected to make the most expressive responses and Masculine subjects the least, while Masculine subjects were most likely to make the oppositional responses and Feminine least likely. None of the groups anticipated much anxiety in making the expressive
responses, but all expected more anxiety when making the oppositional responses, with the Feminine group anticipating significantly more anxiety than any other group. From this study, anxiety and sex role orientation seem to interact when the quality of the stimulus value is varied, but it is interesting to note the relative consistency of the Androgynous groups' responses. Unfortunately, this study did not examine Undifferentiated individuals.

In a study of cognitive schema on the perception of college students with differing sex role orientations, Andersen and Bem (1981) provided subjects with true biographical data, but false photographs of persons with whom they were to contact on the telephone for get-acquainted interviews. The photographs had been previously rated as attractive or unattractive, and after the phone conversation the subjects were to rate their impressions of the persons with whom they had spoken. Each subject had spoken with two males and two females, and of the photos they had been given, one of each sex had been rated attractive. In addition, the conversations were later rated by judges who were blind to the subjects' sex role and the attractiveness of the persons interviewed. The sex typed individuals were more positively impressed with attractive than unattractive persons whom they had contacted, and reported a greater preference for opposite-sexed persons. The Androgynous females in this study reported more posi-
tive feelings toward their unattractive partners than did others, and further, the unattractive partners were rated by the judges as being more stereotypically attractive than the attractive partners of the Androgynous females. The authors suggested that the behaviors of the Androgynous female in this study may support the notion that when individuals are treated in ways that are inconsistent with sex-stereotyped patterns, they are likely to alter their own interactional patterns.

Summary of the Literature

The literature reviewed suggests that classification of individuals by sex role orientation has been a productive approach to examining differences in attitudes and behaviors. The conceptual understanding of persons with respect to sex role and gender has provided a framework from which to examine a broad range of interpersonal functioning, including that which occurs in counseling and therapy situations. It has been shown that differences in behavior are related to the classification of sex role orientation, sex type and gender of the individual (Andersen & Bem, 1981; Casas et al., 1983; Fong & Borders, 1986; Gilbert, 1987; Howard et al., 1969; Wampold et al., 1981). The response styles examined in several studies showed that the Androgynous sex role orientation exhibited wider ranges and more consistency in the variables examin-
ed than either Masculine or Feminine orientations (Andersen & Bem, 1981; Currant et al., 1979; Stokes et al., 1981; Wiggins & Holzmuller, 1978, 1981). Differences in response styles and the internal experiences of subjects also are apparent between Masculine and Feminine orientations according to differential stimulus value (Andersen & Bem, 1981; Carlozzi & Hurlburt, 1982; Currant et al., 1979; Lippa, 1977). The Undifferentiated sex role orientation has had only limited examination in relation to therapist behaviors, but unique characteristics have been demonstrated as a function of this orientation (Fong & Borders, 1985; Fong et al., 1986).

Countertransference, both in totalistic and classical understandings, is an experience which occurs in the therapeutic endeavor and inevitably results in some nuances that may become problematic to the process. Behaviors that are considered representative of countertransference have included various forms of withdrawal of personal involvement, increased therapist report of negative feelings toward the client, and differential treatment of clients in a variety of ways. Therapist variables have also been shown to relate to the degree to which countertransference occurs, including level of therapist trait anxiety (Milliken & Kirchner, 1971; Yulis & Kiesler, 1968), personal conflict (Cutler, 1958), awareness of countertransference feelings (Robbins & Jolkovski, 1987; Schlesinger,
and level of experience (Beery, 1970; Harmell, 1988; Strupp, 1958). Differences in levels of countertransference have also been demonstrated to be related to the stimulus value in various client presentations (Donner & Schonfield, 1975; Howard et al., 1969; Peabody & Gelso, 1982; Russell & Snyder, 1963). The literature seems to suggest that exploration of the variables of sex role orientation and gender are appropriate in the further examination of countertransference. In addition, the exploration of differential levels of countertransference by sex role orientation merits consideration.
CHAPTER III

DESIGN AND METHODOLOGY

Method and Procedure

Subjects

Seventy subjects were randomly selected from graduate students (both at master's and doctoral level) from a listing of 286 students enrolled in classes during the 1989 spring session in the Department of Counselor Education and Counseling Psychology (CECP) training program at Western Michigan University, Kalamazoo. This population was selected because of its generalizability to other studies in which gender and sex role orientation (Buczek, 1981; Fong & Borders, 1985; Fong et al., 1986) and countertransference (Beery, 1970; Peabody & Gelso, 1982; Robbins & Jolkovski, 1987; Strupp, 1958; Yulis & Kiesler, 1968) have been examined, and also because of its availability. These studies also utilized graduate students in counseling or psychology training in their examinations of these subjects. For the purposes of this study it was assumed that this sample population met the criterion of homogeneity with respect to a normative population of graduate level counselors and psychologists in training.
The 70 subjects selected received a letter inviting them to participate in the present study on a voluntary, unremunerated basis (see Appendix A), and also received a phone call within two weeks of the letter encouraging participation and arranging a time for the procedure. Participation in the study was contingent on having no prior knowledge regarding the purpose of the study, which was established at the time of the phone call. One subject from the pool of selected students had some prior knowledge and was disqualified. Four subjects could not be reached by phone or mail, four subjects initially agreed but did not participate, and 10 declined to participate. Of the 70 subjects selected, 51 actually participated in the study, including 32 females and 19 males. Subject anonymity has been insured by keeping all materials in a locked area, by using code numbers on all documents, and by keeping the informed consent forms (the only document on which both the subject's code number and name appear) in a separate, locked location. The study was approved by the Human Subjects Institutional Review Board of Western Michigan University (see Appendix H).

Procedures

The testing took place in designated rooms at the Center for Counseling and Psychological Services, which is the experiential training center for the CECP program.
Subjects were administered the procedure individually or in small groups of up to five, depending upon the times at which they were available to participate. To control for possible contamination of findings due to inconsistency in administration procedures, a standardized format was developed and followed for the researcher's interactions with subjects (see Appendix G). The subjects were greeted at their appointed time by the researcher and asked to sign an informed consent form (see Appendix B). The form stated that subjects would be participating in a therapy analogue study to examine processes which occur in counseling and psychotherapy situations, and that participation would take approximately one hour. Further questions about the purpose of the procedure were deferred until after the completion of the study.

Subjects who chose to participate completed a brief demographic summary (see Appendix F) and the short form of the Bem Sex Role Inventory (BSRI) (Bem, 1981a) (see Appendix C). When subjects had completed these tasks they were given brief verbal introduction regarding the viewing of the videotape (Jolkovski, 1988), as well as a booklet containing concrete and comprehensive instructions (see Appendix D) to insure that the procedure was standardized and streamlined. Any requests for clarification were answered in a non-directive, yet straightforward manner. The researcher was available to assist in case of any
technical difficulties, but none were encountered.

To control for possible effects of the order in which the two female clients were presented in the videotape procedure, a random assignment was made of subjects to one of two tape conditions: one in which client J (low demand) was presented first (version JH) and the other in which client H (high demand) was first (version HJ). Twenty-six subjects were assigned to condition JH, and 25 subjects to condition HJ.

The procedures implemented required no specialized training of the researcher. The Client Transaction Analogue (CTA) was scored according to the instructions in the administration manual provided by its author (Jolkovski, 1989), and the BSRI was scored according to instructions provided by the publisher (see Appendices C and D).

**Independent Variables**

Four independent variables were implemented to examine countertransference behavior in this study.

**Gender.** The gender of the subjects is one of the independent variables. All subjects were classified as male or female. This information was obtained from the completed BSRI forms of each subject.

**Sex Role Orientation.** The classification of each
subject as Masculine, Feminine, Androgynous or Undiffer-
entiated was determined from each subject's completed
protocol using the procedure prescribed by the publisher
for the short form of the Bem Sex Role Inventory (Bem,
1981a). This variable was used to address Hypotheses One,
Two and Three.

**Type of Client Presentation.** The videotape procedure
(Jolkovski, 1988) used in the Client Transaction Analogue
(CTA) countertransference instrument presents two client
types: one considered high demand and the other low de-
mand. The high demand client (Client H) has been charac-
terized as being more forceful and aggressive and the low
demand client (Client J) as more neutral and passive, and
the low demand client has been found to elicit a slightly
lower withdrawal of involvement as measured by the CTA
(Jolkovski, 1989). This variable was used to address Hy-
pothesis Four.

**Demographic Information.** Demographic information was
gathered on a separate instrument (Appendix F) designed by
the researcher to measure the amount of contact hours with
clients, the amount of supervision, and the amount of
hours in the training program each subject had. These
variables were used in post-hoc analyses to determine
other potential sources of difference for countertrans-
ference.
Dependent Variable

The dependent variable in this study was the level of countertransference behavior as measured by scores on the CTA, developed by Jolkovski (1989). This instrument, consisting of a videotape of two female client presentations and a booklet of forced choice responses, measures countertransference behaviors by scoring the choices made by subjects in response to the client presentations. Each client presentation consists of 10 segments during which the client is presenting as in a normal counseling session. The subjects are instructed to respond at appropriate pauses in the tape as though they were this client's therapist. Three choices are offered as alternatives to represent legitimate therapist responses, but have been designed and judged to assess withdrawal of the therapist's involvement from the therapeutic process. While countertransference is certainly more complex than this, similar procedures that measure countertransference behavior have been shown to accurately assess therapist responses that represent this aspect of countertransference (Jolkovski, 1989; Robbins & Jolkovski, 1987; Yulis & Kiesler, 1968).

Three scores are obtained from the CTA which indicate countertransference behavior. Two of the scores are for each of the types of client presentations (Client J and
Client H). The other score is a composite of these two scores, yielding an overall countertransference score. The scores for each type of client presentation were used in the analysis testing Hypothesis One, and the total countertransference score was used in testing Hypotheses One, Two and Three. All three of these countertransference scores were used in examining possible relationships with demographic variables.

Instrumentation

Bem Sex Role Inventory

The Bem Sex Role Inventory (Bem, 1981a) is a self-administered, self-report instrument which classifies persons' sex role orientations as Masculine, Feminine, Androgynous and Undifferentiated. Bem (1974) considers masculinity and femininity as conceptually and empirically distinct rather than assuming that they are bi-polar dimensions of the same construct. This approach has facilitated the dimension of androgyny to be included, occurring when both masculine and feminine traits are endorsed at a significantly high level. Conversely, the Undifferentiated orientation is the result of an individual endorsing neither masculine nor feminine traits at a level sufficient to classify that person in either the Masculine or Feminine orientations.
The BSRI was originally developed by asking male and female college students to respond to 200 descriptors in terms of those words representing a masculine or feminine ideal. The results were then analyzed, and 60 were kept which were determined to be the most significant, 20 stereotypically feminine, 20 stereotypically masculine, and 20 neutral with regard to either masculine or feminine characteristics. The original form of the BSRI asks respondents to rate themselves on a seven point scale on 20 stereotypically feminine traits, 20 stereotypically masculine traits, and 20 neutral traits; however, the instrument is constructed in such a way so that the items are not obvious with respect to the intent.

Normative data provided in the manual (Bem, 1981a) are based upon a 1973 sample of 279 female and 444 male, and a 1978 sample of 340 female and 476 male Stanford University undergraduates. Some other normative data are also provided from non-Stanford Black undergraduates, White undergraduates, Hispanic undergraduates, psychiatric inpatients, and groups of persons in varying age categories other than typical undergraduates. Although there is a difference between the populations on which the normative data were gathered for the BSRI and the population of graduate students used in this study, the validity and reliability of this instrument, as well as the conceptualization of stereotypically traditional sex roles, commend
this instrument as the logical choice.

The reports of internal consistency and reliability are positive. Coefficient alphas for females are reported to be .75 for the Femininity scale and .87 for the Masculinity scale, and for males, .78 for Femininity and .87 for Masculinity. The test-retest reliability originally reported by Bem (1974) proved that over a four week period for 28 males and 28 females, the test was highly reliable (Masculinity $r = .90$; Femininity $r = .90$; Androgyny $r = .93$). Overall reliability is moderately high (test-retest $= .76$ to $94$, internal consistency $= .75$ to $90$). The masculinity and femininity scales are virtually uncorrelated, with none of the reported scale correlations greater than $-.14$.

Bem developed a short form of the BSRI in order to increase the internal consistency. This form consists of 30 items, and it has been found to correlate strongly (about $90$) with the original form's scales. Alphas for the short form of the BSRI are higher for the Femininity scale, and comparable for the Masculinity scale. Payne (1985) advocated use of the short form BSRI over the original, suggesting that the revisions have improved the internal validity of the instrument. In addition, the revision resulted in the deletion of a number of socially undesirable descriptors that were included in the feminine scale that have resulted in greater factorial purity in measuring instrumental and expressive traits. Both the
original and short forms can be scored by computer, but in this study they were hand scored.

**Videotape Procedure for Measuring Countertransference**

The instrument (CTA) for assessing countertransference behaviors in this study was developed by Jolkovski (1989), based on an audiotape procedure originally developed by Yulis and Kiesler (1968) to study this phenomenon. The CTA was developed to assess the level of withdrawal of therapist involvement, a construct which has previously been used to consider countertransference behavior. Jolkovski developed this instrument as a part of his doctoral study, and although he has not yet fully completed reliability and validity studies his preliminary findings are reportedly adequate to commend the use of the CTA. No other instrument available which measures the construct of withdrawal of therapist involvement provided the kind of up-to-date, analogue procedure that Jolkovski's newly developed instrument did.

In Yulis and Kiesler's (1968) original form, the procedure for measuring countertransference consisted of three audiotapes of client-actresses who portrayed roles representing hostile, sexual, and neutral client presentations. Each of the 15-minute presentations was interrupted at crucial spots, and the subjects were asked to make a decision between two possible responses that they...
would make if they were the therapists of these clients. Of the two forced choice responses which were offered, one was considered to be a countertransference response, in that it represented a withdrawal of involvement from the client, consistent with a theoretical and clinical conceptualization of this process. The other response option represented what was considered to be a therapeutic response. Both responses were judged by experienced psychologists to be credible options, and to represent the types of responses the authors proposed. This instrument was used in other studies, in original and altered forms, to measure countertransference behaviors (Peabody & Gelso, 1982; Robbins & Jolkovski, 1987).

The CTA procedure used in this present study was developed by Jolkovski (1989) based on Yulis and Kiesler's (1968) method, in that it also assesses levels of therapist's withdrawal of involvement. However, Jolkovski has attempted to update the procedure to reflect more contemporary clients. The CTA procedure presents two client types: one which is characterized as less demanding (client J), and the other as more demanding (client H). In preliminary studies, Robbins and Jolkovski (1987) have found that the high demand client presentation elicits somewhat more withdrawal of involvement than does the low demand client. The high demand client is based on Yulis and Kiesler's (1968) more hostile client and the low
demand client is based on the neutral client in the original study. This updated version has been developed by Jolkovski (1989) over the last several years and is currently being analyzed for validity and reliability. Jolkovski developed scripts for the client types through processes involving pilot studies, extensive feedback and revision suggestions from six doctoral level psychologists (including four women), and the assistance of a professional fiction writer. He then had two actresses enact the client roles which had been devised and the CTA videotape was developed from this, with each client presentation consisting of 10 segments with response options at appropriate intervals to assess therapist withdrawal of involvement. The response triads were judged by a team of experienced judges to be believable responses that could be made to a client, and these judges rated the triads according to level of withdrawal of involvement. The responses were revised until each triad had a minimal level of inter-rater agreement (Kendall's $W > .75$). Preliminary findings indicated that this instrument accurately and realistically presents varying types of client presentations and measures subjects' countertransference behaviors, operationalized as level of withdrawal of involvement from the therapeutic situation.

The CTA procedure developed by Jolkovski was used in this study with only a minor adaptation; a videotape was
made which reversed the order of client presentation in the original videotape. This facilitated control of the possible effects of order of presentation of the two cli-
ent types. On the original CTA videotape procedure, Cli-
ent J was presented first and Client H was presented last.
The alternate form which was made for this study reversed this order, presenting Client H initially and Client J last. No other changes in the procedure were made, insur-
ing that the results in this study were not contaminated by such alterations and therefore, were more cleanly interpretable.

The CTA procedure is appropriate for this study because it has been shown in other studies to provide adequate stimulus value to produce countertransference responses, and because it provides a method for quanti-
ifying the response through an analogue procedure. The types of client presentations represent two kinds of clients, each of which might be expected to evoke differential countertransference responses from therapists.

Research Hypotheses

The models utilized for the analyses of the data included one-way Analysis of Variance (ANOVA) and t tests. The demographic information was analyzed using one-way ANOVA's to determine if these factors demonstrate signifi-
cant relationships to countertransference scores.
Hypothesis One

Sex role orientation will predict the level of countertransference behavior. A one-way ANOVA examining subjects' total countertransference scores by sex role orientation was used to test this hypothesis. It was expected that significant differences would be found between sex role orientations.

Hypothesis Two

Subjects with Androgynous sex role orientation will demonstrate less countertransference behavior than other sex role orientations. The same ANOVA procedure used to test Hypothesis One was used to test this hypothesis. The mean scores of each sex role orientation category were to subsequently be analyzed using simultaneous confidence intervals to determine which sex role orientations produced higher and lower countertransference behavior scores.

Hypothesis Three

Subjects with Masculine sex role orientation will demonstrate more countertransference behaviors than other sex role orientations. Again, the ANOVA procedure used for Hypotheses One and Two was used to answer this hypothesis. The same subsequent analyses regarding
simultaneous confidence intervals were planned to examine higher and lower levels of countertransference behavior by sex role orientation.

Hypothesis Four

Subjects with sex typed orientations (Masculine and Feminine) will demonstrate significant differences in countertransference behavior as a result of type of client presentation, and neither Androgynous or Undifferentiated sex role orientations will demonstrate significant differences. The mean scores for countertransference for each type of client presentation (Client J and Client H) for each category of sex role orientation was tested for significance using t tests to determine if significant differences could be detected in the hypothesized categories.
Sample Description

Seventy subjects (24.48%) were randomly selected from the available population of 286 graduate students. Of this selected sample, 45 (64.29%) were females and 25 (35.71%) were males. From the 70 subjects selected, 51 (72.86%) actually participated in the study. Of the subjects who participated, 32 (62.75%) were females and 19 (37.25%) were males. Thirty-one (60.78%) of the participants were masters level students and 20 (39.22%) were doctoral students. The mean age for all subjects participating in this study was 34.6 with a standard deviation of 7.3 and a range of 21 to 59. The means for males and females were 35.6 and 34.0, respectively.

Two of the subjects participating in the study were visually impaired, which led to some slight modifications in the administration procedures. To control for the possibility that these subjects' scores may have affected the overall findings, their scores and all other subjects' scores were analyzed using a one-way ANOVA. The resulting F probability of .312 indicated that no significant
differences existed between visually impaired versus sighted subjects. The absence of a significant difference leads to the question of how useful the visual stimuli of these videotaped client presentations were.

The demographic information gathered from the form initially completed by subjects (see Appendix F) indicated that there was some variety among subjects' responses, although in the categories of classes taken and number of clients seen, a larger proportion of subjects endorsed the highest options available: 49.02% had taken more than 10 classes and 41.18% had seen more than 15 clients. Subjects' responses to the number of hours of supervision they had received were more consistently found at either high or low options rather than the three other mid-range options. Of the five response options, 31.37% of the subjects indicated that they had received no supervision and 39.22% indicated that they had received more than 30 hours of supervision, while less than 30% of the subjects endorsed either of the three other options.

In order to control for possible effects resulting from the order of presentation of the two client types in the countertransference procedure, random assignment was made of 25 subjects to the videotape procedure HJ presenting Client H (high demand) first and 26 subjects were shown the videotape procedure JH with Client J (low demand) first. The total countertransference mean scores
of these two groups were analyzed using a one-way ANOVA to determine if a significant difference would result from order of presentation. The $F$ probability of this analysis was .145, considerably above the .05 level of significance, leading to a determination that the order of client presentation was not a significant factor in the level of countertransference exhibited by subjects in this study. If it had been found that the level of countertransference responses was influenced by the order of client presentation, the interpretation of the results may have been confounded. Such results may have suggested that subjects' countertransference responses were a function of the order of presentation rather than simply the response to the stimulus value of the client. This was not found to be the case; therefore, the countertransference responses of the subjects can be assumed to be free from contamination due to the order of presentation.

Countertransference Instrument

Because the instrument for measuring countertransference behavior is relatively new and limited information is available regarding its reliability, an analysis was performed to determine the reliability coefficients for both client presentations and overall countertransference scores. For Client J the reliability analysis produced a Chronbach's alpha of 0.69; for Client H Chronbach's alpha
was 0.63. The reliability analysis for total countertransference scores resulted in a Chronbach's alpha of 0.77. These findings indicate that the results of this study should be interpreted in light of the limitations of the reliability of the countertransference measure. The reliability of the overall countertransference scores is acceptable at 0.77, but the alphas for the separate countertransference scores for Client H and Client J suggest that interpretations using these as variables should be more tentative. While the reliability of the total countertransference scores used in answering Hypotheses One, Two and Three was higher than the reliability of either of the two client presentations, none of these findings are sufficient to make inferential statements about the results. They are sufficiently high to make descriptive statements regarding Hypotheses One, Two and Three, but interpretations regarding Hypothesis Four must be considered more tentatively. The implications of the reliability findings will be discussed further in Chapter V.

Results

In order to facilitate comparison with previous studies which studied gender and countertransference, the mean and standard deviation scores for subjects' countertransference responses according to gender are reported in Table 1. Although this information is not necessary to
address the proposed hypotheses, it is reported here and used to analyze the potential relationship of gender to countertransference scores in the sample population.

Table 1

<table>
<thead>
<tr>
<th>Gender</th>
<th>n</th>
<th>%</th>
<th>Countertransference Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>32</td>
<td>62.75</td>
<td>45.781</td>
<td>5.546</td>
</tr>
<tr>
<td>Male</td>
<td>19</td>
<td>37.25</td>
<td>43.368</td>
<td>8.668</td>
</tr>
<tr>
<td>Total</td>
<td>51</td>
<td>100</td>
<td>44.882</td>
<td>6.893</td>
</tr>
</tbody>
</table>

Although gender was not included as one of the primary hypotheses under consideration, a one-way ANOVA was performed. This was done to assess this sample's consistency with previous studies. The analysis revealed no significant differences between males and females, consistent with previous findings in which gender of the therapist was not related to countertransference phenomena (Abramowitz, Abramowitz & Weitz, 1976; Abramowitz, Abramowitz, Roback, Corney & McKee, 1976; Abramowitz, Roback, Schwartz, Yasuma, Abramowitz & Gomes, 1976). The results of this ANOVA are presented in Table 2.
Table 2

One-Way ANOVA for Countertransference by Gender

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig. level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between groups</td>
<td>69.404</td>
<td>1</td>
<td>69.404</td>
<td>1.475</td>
<td>.230</td>
</tr>
<tr>
<td>Within groups</td>
<td>2305.890</td>
<td>49</td>
<td>47.060</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2375.294</td>
<td>50</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Tests for Homogeneity of Variance:

- Cochran's C-test: .7095, $P = .03$
- Bartlett's test: 4.66, $P = .031$

The summary statistics which were used to test the proposed hypotheses regarding countertransference and sex role orientation are presented in Table 3.

Findings from the one-way ANOVA utilized to test Hypotheses One, Two, and Three are displayed in Table 4. The results indicate that in the sample examined, differences in overall countertransference scores between sex role orientation groups were non-significant, with the F probability reaching .743.

To answer the question proposed by Hypothesis Four, t tests were performed on the two means in each sex role orientation classification of the countertransference.
Table 3
Summary Statistics for Sample Subjects for Sex Role
Orientation by Countertransference Scores

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>18</td>
<td>12</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>CT. mean</td>
<td>45.28</td>
<td>44.42</td>
<td>43.1</td>
<td>46.36</td>
</tr>
<tr>
<td>standard deviation</td>
<td>8.02</td>
<td>6.37</td>
<td>6.69</td>
<td>6.89</td>
</tr>
<tr>
<td>Standard error</td>
<td>1.89</td>
<td>1.84</td>
<td>2.12</td>
<td>1.84</td>
</tr>
<tr>
<td>Minimum</td>
<td>23</td>
<td>35</td>
<td>33</td>
<td>38</td>
</tr>
<tr>
<td>Maximum</td>
<td>57</td>
<td>54</td>
<td>54</td>
<td>55</td>
</tr>
</tbody>
</table>

scores derived from each of the two client presentations. The summary statistics used to perform these t tests are presented in Table 5.

The results of the t tests performed on the Client J and H Countertransference means for each sex role orientation are presented in Table 6. In all t tests the critical value for t was considerably greater than the absolute value for t obtained, leading to a decision to retain the null hypothesis.

The results presented in Tables 7, 8, and 9 were used in analyses performed to determine if any of the
Table 4
One-Way ANOVA for Countertransference by Sex Role Orientation

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig. level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between groups</td>
<td>61.321</td>
<td>3</td>
<td>20.440</td>
<td>.415</td>
<td>.743</td>
</tr>
<tr>
<td>Within groups</td>
<td>2313.973</td>
<td>47</td>
<td>49.234</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2375.294</td>
<td>50</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Tests for Homogeneity of Variance:

Cochran's C test: .3444  P = .572
Bartlett's test: .406  P = .749

demographic factors were related to countertransference scores. Table 7 presents the summary statistics for the number of classes taken in the subjects' training programs and the mean countertransference scores for Client J, Client H and total countertransference scores for each of the categories.

Table 8 presents the summary statistics for the number clients seen by the subjects, as well as countertransference mean scores attained in each category for Client J, Client H and total countertransference.

Table 9 presents the approximate number of

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Table 5

Summary Statistics for Countertransference by Type of Client Presentation by Sex Role Orientation

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>18</td>
<td>12</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Client J mean</td>
<td>22.44</td>
<td>21.75</td>
<td>21.70</td>
<td>23.73</td>
</tr>
<tr>
<td>J standard deviation</td>
<td>4.64</td>
<td>3.98</td>
<td>4.22</td>
<td>3.04</td>
</tr>
<tr>
<td>J standard error</td>
<td>1.09</td>
<td>1.15</td>
<td>1.33</td>
<td>.92</td>
</tr>
<tr>
<td>J minimum</td>
<td>12</td>
<td>17</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>J maximum</td>
<td>30</td>
<td>27</td>
<td>30</td>
<td>28</td>
</tr>
<tr>
<td>Client H mean</td>
<td>22.83</td>
<td>22.67</td>
<td>21.40</td>
<td>22.64</td>
</tr>
<tr>
<td>H standard deviation</td>
<td>4.40</td>
<td>3.26</td>
<td>3.89</td>
<td>3.98</td>
</tr>
<tr>
<td>H standard error</td>
<td>1.04</td>
<td>.94</td>
<td>1.23</td>
<td>1.20</td>
</tr>
<tr>
<td>H minimum</td>
<td>11</td>
<td>18</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td>H maximum</td>
<td>27</td>
<td>28</td>
<td>26</td>
<td>28</td>
</tr>
</tbody>
</table>

Also presented in this table are the corresponding mean countertransference scores of Client J, Client H and total countertransference for each of the categories.
Table 6

| SRO            | $|t|$ obtained | critical $t$ | conclusion |
|----------------|----------------|--------------|-------------|
| Androgynous    | 0.259          | 2.12         | no difference |
| Undifferentiated| 0.619          | 2.23         | no difference |
| Feminine       | 0.166          | 2.31         | no difference |
| Masculine      | 0.721          | 2.26         | no difference |

Table 7

Demographic Information—Number of Classes Taken and Mean Countertransference Scores

<table>
<thead>
<tr>
<th>Classes taken</th>
<th>1 - 3</th>
<th>4 - 6</th>
<th>7 - 10</th>
<th>More than 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>8</td>
<td>12</td>
<td>6</td>
<td>25</td>
</tr>
<tr>
<td>%</td>
<td>15.69</td>
<td>23.53</td>
<td>11.76</td>
<td>49.02</td>
</tr>
<tr>
<td>J mean</td>
<td>22.63</td>
<td>23.08</td>
<td>22.17</td>
<td>22.08</td>
</tr>
<tr>
<td>H mean</td>
<td>22.00</td>
<td>22.58</td>
<td>22.67</td>
<td>22.52</td>
</tr>
<tr>
<td>Total</td>
<td>44.63</td>
<td>45.67</td>
<td>44.83</td>
<td>44.60</td>
</tr>
</tbody>
</table>
Table 8
Demographic Information—Number of Clients Seen and Mean Countertransference Scores

<table>
<thead>
<tr>
<th>Clients seen</th>
<th>1 - 4</th>
<th>5 - 8</th>
<th>9 - 15</th>
<th>15+</th>
</tr>
</thead>
<tbody>
<tr>
<td>none</td>
<td>20</td>
<td>6</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>%</td>
<td>39.22</td>
<td>11.76</td>
<td>3.92</td>
<td>3.92</td>
</tr>
<tr>
<td>J mean</td>
<td>23.25</td>
<td>23.17</td>
<td>25.50</td>
<td>24.00</td>
</tr>
<tr>
<td>H mean</td>
<td>22.20</td>
<td>25.33</td>
<td>25.00</td>
<td>24.00</td>
</tr>
<tr>
<td>Total</td>
<td>45.45</td>
<td>48.50</td>
<td>50.50</td>
<td>48.00</td>
</tr>
</tbody>
</table>

The post-hoc analyses performed on the demographic information gathered were analyzed using one-way ANOVAs, with the countertransference scores as the dependent variable. Of the analyses performed, the only one which reached significance (p<.05) was that of the responses for Client J by the amount of supervision (p=.047). These findings are displayed in Table 10. None of the other demographic information gathered with this population exhibited levels of significance with respect to countertransference behavior scores.
Table 9
Demographic Information—Hours of Supervision and Mean Countertransference Scores

<table>
<thead>
<tr>
<th>Hours of supervision</th>
<th>none</th>
<th>1 - 10</th>
<th>11 - 20</th>
<th>21 - 30</th>
<th>30+</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>16</td>
<td>6</td>
<td>4</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>%</td>
<td>31.37</td>
<td>15.69</td>
<td>7.84</td>
<td>5.88</td>
<td>39.22</td>
</tr>
<tr>
<td>J mean</td>
<td>22.63</td>
<td>25.88</td>
<td>20.75</td>
<td>23.67</td>
<td>21.00</td>
</tr>
<tr>
<td>H mean</td>
<td>22.00</td>
<td>24.25</td>
<td>24.75</td>
<td>25.67</td>
<td>21.20</td>
</tr>
<tr>
<td>Total</td>
<td>44.63</td>
<td>50.13</td>
<td>45.50</td>
<td>49.33</td>
<td>42.20</td>
</tr>
</tbody>
</table>

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## Table 10
One-Way ANOVA for Client J Countertransference by Amount of Supervision

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig. level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between groups</td>
<td>152.311</td>
<td>4</td>
<td>38.078</td>
<td>2.614</td>
<td>.047*</td>
</tr>
<tr>
<td>Within groups</td>
<td>670.042</td>
<td>46</td>
<td>14.566</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>822.353</td>
<td>50</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Tests for Homogeneity of Variance:

- Cochran's C test: $C = 0.3283$, $P = 0.374$
- Bartlett's test: $B = 0.822$, $P = 0.511$

* $p < .05$
A one-way Analysis of Variance (ANOVA) was used to test Hypothesis One, Two and Three. These hypotheses were stated as follows: "Sex role orientation will predict the level of countertransference behavior" (One), "Subjects with Androgynous sex role orientation will demonstrate less countertransference behavior than other sex role orientations" (Two), and "Subjects with Masculine sex role orientation will demonstrate more countertransference behavior than other sex role orientations" (Three). The results of the analysis used to test these three hypotheses were nonsignificant. In this study, countertransference was not shown to differ significantly according to sex role orientation of subjects. Hypothesis Four, "Subjects with sex typed orientations (Masculine and Feminine) will demonstrate significant differences in countertransference behavior as a result of type of client presentation and neither Androgynous or Undifferentiated sex role orientations will demonstrate significant differences," was tested using t tests to determine if significant differences
existed between Client J and Client H countertransference means in each sex role orientation category. The results of these tests were also nonsignificant. Level of countertransference behavior, operationalized as withdrawal of therapist involvement and understood as a negative form of countertransference in this analogue study, was shown to have no relationship with sex role orientations of the subjects.

The results of the analyses of countertransference scores and other demographic information provided limited information regarding other factors which may be related to countertransference behaviors. The only ANOVA which yielded significant results was that which examined the amount of supervision reported and the countertransference scores obtained for Client J, the low demand client presentation. The ANOVA of Client J countertransference scores and the amount of supervision resulted in $P = 0.047$ in this sample, which is significant at the .05 level. This may represent a new finding in terms of factors which influence countertransference; however, the findings should be considered in light of the reliability analyses performed on the countertransference instrument, which produced a Chronbach's alpha of 0.69. This relatively low reliability score, combined with the small numbers of subjects in each of the sex role orientation categories involved in the $t$ tests (Androgynous $N=18$, Undifferentiated
Interpretation of Analyses

Hypothesis One

**Sex role orientation will predict the level of countertransference behavior.** A one-way ANOVA, examining subjects' total countertransference scores by sex role orientation, was used to test this hypothesis. It was expected that significant differences would be found between sex role orientations. However, no significant differences were found. These results indicate that the sex role orientations of therapists in this study are not significantly related to the levels of countertransference behavior exhibited by the therapists.

As previously indicated, the instrument used to measure the level of countertransference behavior in this study was originally constructed to assess the therapist's withdrawal of involvement in the therapeutic situation. Consideration needs to be given to the possibility that countertransference behavior encompasses much more than that which is represented by the instrument used in this
study to measure it. This construct, withdrawal of involvement, while theoretically appropriate as one aspect of the broad spectrum of countertransference phenomena, is nevertheless limited in its representation of countertransference behaviors. In this study, the construct of withdrawal of involvement by the therapist has facilitated the examination of one particular aspect of the range of countertransference behavior which may be related to the sex role orientation of the therapist. Although countertransference and sex role orientation were not shown to have a significant relationship, it cannot be concluded that there is no relationship between these two concepts. The present results indicate that for this sample of counselor trainees withdrawal of therapist involvement from the client cannot be predicted by the counselor's sex role orientation.

Hypothesis Two

Subjects with Androgynous sex role orientation will demonstrate less countertransference behavior than other sex role orientations. The same ANOVA procedure used to test Hypothesis One was used to test this hypothesis. If the ANOVA had yielded significant results the mean scores would have been compared by examining simultaneous confidence intervals to determine which sex role orientations produced higher and lower countertransference behaviors.
However, the ANOVA procedure indicated that no statistically significant differences existed between sex role orientation categories, so further analyses were unnecessary.

Hypothesis Three

Subjects with Masculine sex role orientation will demonstrate more countertransference behaviors than other sex role orientations. Again, the ANOVA procedure used for Hypotheses One and Two was to be used to answer this hypothesis. The same procedure regarding simultaneous confidence intervals would have been employed if the ANOVA had produced significant results in examining higher and lower levels of countertransference behavior by sex role orientation. However, since significant levels for differences were not found, no further analyses were appropriate.

Hypothesis Four

Subjects with sex typed orientations (Masculine and Feminine) will demonstrate significant differences in countertransference behavior as a result of type of client presentation, and neither Androgynous or Undifferentiated sex role orientations will demonstrate significant differences. The mean scores for countertransference for each type of client presentation (Client J and Client H) for
each category of sex role orientation were tested for significance using \( t \) tests to determine if significant differences existed between the hypothesized categories.

It was expected that the Androgynous and Undifferentiated sex role orientation groups would respond similarly to each of the two client presentations (Client J and Client H), and would exhibit no significant difference on countertransference behavior scores between these two presentations. The Masculine and Feminine sex role orientations, conversely, were each expected to demonstrate significant differences in the countertransference scores produced in response to Client J and Client H presentations. These findings were expected because of the anticipated stereotypical response styles of Masculine and Feminine sex role orientation groups. It was expected that these two groups would have more countertransference behaviors with one type of client, and less with the other type of client. The client presentations represented in the CTA procedure represented high and low demand clients, and although this instrument has not been used specifically to demonstrate differential responding in subjects, such differential effects have been observed (Jolkovski, 1989). It was expected that stereotypical response styles would elicit more differences in the amount of countertransference behaviors than would either the Androgynous or Undifferentiated sex role orientations. Since these
differences were not found, it may be concluded that for this representative sample there is no difference in the amount of countertransference behavior between sex role orientations.

Demographic Information

The results of analyses considering demographic variables should be considered tentatively. These variables, including gender, amount of contact hours with clients, the amount of supervision, and the amount of hours in the training program each subject has, were analyzed using a one-way ANOVA, with Client J, Client H and total countertransference scores as the dependent variables.

The only analysis which reached significance was that which considered amount of supervision and the countertransference scores for Client J. The $F$ probability for the ANOVA for supervision and Client H was .108, and for the total countertransference score and supervision the $F$ probability was .055. The fact that significance was not demonstrated for supervision in relationships with Client H and total countertransference scores suggests that the significant finding for Client J may not be entirely due to an intrinsic relationship between supervision and countertransference behavior. However, since both ANOVA procedures for Client H and total countertransference scores produced $F$ probabilities that were less than .11, the risk...
of committing a Type II error must be considered if one infers from these results that amount of supervision is not related to countertransference behavior. Further confounding the consideration of this question is the fact that the group size for each of the categories used to analyze for differences was small in some cases and larger in others (n range, 3-20). This small n results in tentativeness in making inferences and interpretations about the results, and further study which controls such differences in the n's may be useful.

Discussion

Since no significant relationships were demonstrated between sex role orientation and countertransference behavior in this study, it could be concluded that gender and sex role orientation are not therapist characteristics that influence countertransference. While no previous studies have examined sex role orientation and countertransference, the limited research on gender and countertransference has tended to support the notion that no firm relationship existed between these variables (Abramowitz, Abramowitz & Weitz, 1976; Abramowitz, Abramowitz, Roback, Corney & McKee, 1976; Buczek, 1981).

However, drawing the conclusion from this study that sex role orientation, gender and countertransference are not related would be inappropriate. Theoretical and
empirical efforts have suggested that observable behavioral differences may exist between individuals of various sex role orientations. While these differences were not apparent in this study, this does not necessarily mean that real differences are nonexistent. Several considerations must be entertained regarding the scope and design of this study which impact the conclusions drawn.

As stated in Chapter I, the construct which was chosen for countertransference was the withdrawal of therapist involvement in an analogue therapeutic situation. This construct is obviously narrow, and represents only a single aspect of a negative form of countertransference to be considered. It does not consider the therapists' reports of their experiences with the two client presentations, nor does it consider alternative explanations regarding why withdrawal of involvement might, or might not, occur for reasons other than countertransference. Both the totalistic and the classical understandings of countertransference encompass a much broader understanding of this subject. Therefore, the results of this study represent an examination of only one aspect of a much larger subject area, and further exploration is needed. If sex role orientation or other gender-related differences are factors in the levels of countertransference exhibited or experienced by therapists, then there are clinical and training implications. However, recommendations based on
the findings of this study only would be inappropriate.

The findings observed between level of therapist experience and countertransference behavior in this study are consistent with the previous literature's inconsistency on this topic. Strupp (1958), Beery (1970) and Harmell (1988) concluded from their findings that the level of therapist experience was somewhat of a factor in the amount of countertransference (or countertransference-related) phenomena they observed, although various other factors may also be involved. Conversely, Russell and Snyder (1963) and Robbins and Jolkovski (1987) concluded from their studies that the level of countertransference behavior was not influenced by therapist level of experience. The diversity of conclusions in empirical studies is apparent in theoretical writings, as well.

Freud's (1910/1964) position was that regardless of how experienced the analyst was, countertransference could occur. Thus, he offered that in overcoming countertransference, the analyst's own analysis should not be a single, isolated experience but more of an ongoing process. The totalist understanding of countertransference suggests that this phenomenon may occur as a result of level of experience, but that the important consideration is not whether it occurs but how to recognize and use it therapeutically (Kernberg, 1965). While level of therapist experience in relation to countertransference is not a
critical consideration for either classical or totalist positions, it does bear further examination. Increasing therapists' understandings of what countertransference phenomena can be expected as they approach the therapeutic endeavor can increase their own awarenesses and thus, increase the likelihood of managing their countertransference more effectively (Robbins & Jolkovski, 1987; Schlesinger, 1984). Further study is needed in this area.

The contribution which this present study makes is that it builds upon previous theoretical and empirical literature by systematically examining the relationship of one form gender-related identity (sex role orientation) and one aspect of countertransference (understood as negative withdrawal of involvement). The findings of non-significance between these constructs further clarifies therapist attributes which may impact on the therapeutic endeavor, and perhaps continues movement in a direction which will lead to a meta-analysis of countertransference phenomena. The design employed was one which utilized random selection procedures, which is unique from many previous studies in an attempt to increase statistical power. This should be construed as an effort to more conscientiously examine countertransference, and represents a contribution to the literature in itself.
Limitations

As previously stated, the operational definition used for countertransference in this study, withdrawal of therapist involvement, presents some limitations to the subject being examined. Countertransference is certainly much more than the therapist withdrawing, or defending, within the therapeutic context. Additionally, the specific reason for the apparent withdrawal of involvement may not necessarily be countertransferenceal. It is conceivable that subjects may exhibit behaviors which appear to be withdrawing from the client when in fact they are making clinical decisions based upon a particular theoretical framework. Robbins and Jolkovski (1987) examined the procedure developed by Yulis and Kiesler (1968) to determine the relationship of countertransference to theoretical orientation and found no differences, except that the more a subject adhered to a theoretical framework, the less countertransference was exhibited. However, the instrument which was used to measure countertransference in this study, which was recently developed by Jolkovski (1989) has not been examined for potential differences in theoretical framework.

Further limitations are apparent in the instrument used to assess countertransference behavior, in that the client presentations were both females. One might expect
differential levels of countertransferential responses if the client presentations had been varied by gender, as suggested by Howard and associates (1969), Gilbert (1987) and Andersen and Bem (1981). If subjects of various sex role orientations had been asked to respond to both a male and a female client presentation, one might wonder what effects would have been observed in the testing of Hypothesis Four. More significant differences might have been expected in the proposed direction, since the stimulus value for subjects with masculine and feminine sex role orientations may have been more profound.

Another limitation apparent in this study is the small sample size in the sex role orientation distributions upon which the analyses were conducted. The relatively small n's represented (Androgynous n=18, Undifferentiated n=12, Feminine n=10, Masculine n=11) make it necessary to interpret the data in tentative ways, and larger sample sizes would make analyses less ambiguous.

Suggestions for Future Research

Further research is indicated from the findings of this study. While the results indicated that no significant differences were apparent between sex role orientation, gender and countertransference behavior, additional examination of these relationships is merited. As previously stated, alternative conceptualizations of the

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construct of countertransference may be useful in future research efforts exploring countertransference and sex role orientation. The examination of the effects of sex role orientation and countertransference using other instruments may reveal relationships which were not apparent in this study, and would enhance understanding of countertransference phenomena. A particularly useful research direction might be in developing other instruments which measure specific aspects of countertransference, such as withdrawal of involvement, but which correlate the results with the subjects' reports of feelings and attitudes that might be indicative of countertransference. This would contribute consistency between countertransference behaviors and the therapist's internal experience of the client, which would strengthen the validity of the instrument.

Future studies which focus on the relationship between sex role orientation and countertransference behavior may benefit from alternative design methodologies. The classification of sex role orientations from a population will almost certainly result in a variety of sample sizes among various orientations. Designs which employ large enough numbers of subjects to assure relatively large sample sizes in each sex role orientation may prove useful. This would reduce the tentativeness in interpretation of relatively small and unequal sample sizes. It
may also increase the power of the design to examine these relationships using equal distributions of males and females, in addition to controlling the sample sizes of sex role orientation. The development of instruments measuring countertransference which employ both male and female client presentations would greatly enhance future exploration of this topic.

Finally, continued examination of the relationship between level of therapist experience and countertransference is warranted. Previous theoretical and empirical work has presented disparity regarding the relationship of these variables, and findings have been inconsistent. The results of this study also exhibit some inconsistency when considering hours of supervision and countertransference, indicating that perhaps some relationship exists, but the precise nature of that relationship is uncertain. Future efforts to clarify these discrepant findings would be useful.

Summary and Conclusions

This study sought to examine the relationships between sex role orientation and countertransference behavior. The findings indicated that no significant relationships existed between the constructs used; however, this does not necessarily imply that no relationship exists. The instrument used to examine the construct for
countertransference behavior exhibited some limitations in addressing the questions asked. While withdrawal of involvement as a form of countertransference may not be related to sex role orientation or gender, other types of countertransference phenomena may prove to be related. An interesting additional finding was that hours of supervision showed some significant relationship to countertransference behavior, although the results are certainly not conclusive. Further study is needed to better understand these relationships and how they impact the training and clinical work of counseling and psychotherapy.
Appendix A

Cover Letter
May 18, 1989

Dear CECP Graduate Student:

This letter is to request your participation in an analogue study to better understand what occurs in the counseling process. You have been selected from Counselor Education and Counseling Psychology graduate students at Western Michigan University as a candidate for this study, which is part of a doctoral dissertation research with E. L. Trembley, D. Ed., as my chair. As a counseling graduate student, I am sure that you appreciate the importance of learning more about what occurs in the counseling process. Your participation in this study is strictly voluntary, but I hope that you will choose to be involved.

Your participation will require approximately one hour of your time, and will take place in the CECP Department. You will be asked to respond to written and audiovisual material which, as a counselor, you are likely to find quite interesting. Measures will be taken to assure your anonymity with regard to results, and consideration has been given to the Ethical Principles in the Conduct of Research with Human Participants which is published by the American Psychological Association (1981). This study has been approved by the W.M.U. Human Subjects Institutional Review Board and by the CECP department chairperson, Dr. Alan Hovestadt.

You will be contacted within the next week or two to enlist your participation and arrange a time that is convenient for you. Again, I hope that you will plan to participate in this research project. Thanks for your consideration.

Sincerely,

Scott T. Luppe, M.A.
Ed. D. Candidate
Appendix B

Informed Consent
Informed Consent

This analogue study is a research project prepared to clarify some of the processes which occur in counseling and psychotherapy settings. If you agree to participate in this study, you will be asked to spend approximately one hour viewing a videotape of two client presentations, choosing from multiple options responses that you would make if this were your client, and completing demographic and characteristic information. Your participation is entirely voluntary, and you are free to decline participation at any time.

There has been no attempt to conceal any information in this process. Although you may experience some measure of discomfort in this process, as you might in any counseling session, it is anticipated that such occurrences will add to your professional and personal growth as a clinician. Detrimental effects are not foreseen.

If you decide to be a participant, please sign below and return this form to the investigator. Confidentiality will be assured through code numbers, and no information that personally identifies you will be released at any time. Informed consent forms will be kept entirely separate from any other materials.

Consent

I understand my rights as a subject and agree to participate in this study.

__________________________  ____________  ________
Subject's Signature        Date        Subj.  #

__________________________  ____________
Investigator's Signature    Date
Appendix C

Bem Sex Role Inventory (BSRI)

110
PLEASE NOTE:

Copyrighted materials in this document have not been filmed at the request of the author. They are available for consultation, however, in the author's university library.

These consist of pages:

111–112
Appendix D

Client Transaction Analogue
Countertransference Instrument
Client Transaction Analogue

Instructions and Answer Sheet

This form is to be used with the Client Transaction Analogue videotape. All necessary instruction are on the tape.

The analogue will require you to put yourself in the place of a therapist and choose your responses to the "clients" from the alternatives provided, and record your choices on this form.

Be sure to record the letter which identifies each client.

Note. From "Client Transaction Analogue" by M. P. Jolkovski, 1988, Virginia Commonwealth University. Adapted by permission.
CTA Answer Sheet

Page 1

Mark through the item you choose

Client #____

<table>
<thead>
<tr>
<th>Segment</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

At the end of the first "client" interview
keep the tape rolling
turn the page
and prepare to meet the second "client"
CTA Answer Sheet
Page 2

Mark through the item you choose

<table>
<thead>
<tr>
<th>Client #___</th>
<th>Segment 1:</th>
<th>Segment 2:</th>
<th>Segment 3:</th>
<th>Segment 4:</th>
<th>Segment 5:</th>
<th>Segment 6:</th>
<th>Segment 7:</th>
<th>Segment 8:</th>
<th>Segment 9:</th>
<th>Segment 10:</th>
</tr>
</thead>
<tbody>
<tr>
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<td>A</td>
<td>B</td>
<td>C</td>
<td>A</td>
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<td>C</td>
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<td>C</td>
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<td>C</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>A</td>
</tr>
</tbody>
</table>

At the end of the second "client" interview
rewind the tape
Appendix E

Letter of Permission: Client Transaction Analogue
Dear Mr. Jolkovski:

I am a graduate student in the Department of Counselor Education and Counseling Psychology at Western Michigan University, Kalamazoo, Michigan. Toward the completion of my doctoral dissertation, I would like to use the videotape procedure you have developed for measuring countertransference responses.

My study will examine the effects of sex role orientation on countertransference behaviors in graduate level counselors in training. The Bern Sex Role Instrument (BSRI) (Bern, 1981) will be used to determine sex role type, and your procedure will be used to assess the level of countertransference responses. This study has been approved by my doctoral committee, as indicated by my committee chairperson's (E. L. Trembley, D. Ed.) signature.

If you approve, please sign below and return to me in the enclosed stamped, self addressed envelope. Thank you.

Sincerely,

Scott T. Luppe, M.A., L.L.P.
Doctoral Candidate

Michael Jolkovski, Ph. D. Cand.

E. L. Trembley, D. Ed., Chairperson

Date

May 17, 1989
Appendix F

Demographic Information
Demographic Information

Subject # _____

Please complete the following questions:

1. How many classes have you taken in your counseling degree program?
   ___ 1-3   ___ 4-6   ___ 7-10   ___ more than 10

2. Approximately how many clients have you worked with?
   ___ none   ___ 1-4   ___ 5-8   ___ 9-15   ___ 15+

3. Approximately how many hours of supervision have you had?
   ___ none   ___ 1-10   ___ 11-20   ___ 21-30   ___ 31+
Appendix G

Format for Facilitators
Format for Facilitators

A. The facilitator will greet and ask subject to read informed consent form.

B. After form is signed by subject and facilitator, a number is assigned from a master list of subjects and this is written on all of the forms that will be used in the assessment (CTA, BSRI, Demographic Information) by the facilitator.

C. The facilitator will give the subject a pencil, the BSRI and the Demographic Information form and say, "Please complete the Demographic Information form and the Bem Inventory form. The instructions for the Bem Inventory are included; just read them and follow the directions. Please stop at the heavy black line after the item 'conventional'. Let me know when you are finished."

D. After subject has completed forms, the facilitator will collect them, double check to be sure the number is included on each form, and be sure that all information is completed. If it is not, the subject will be asked to finish what is incomplete, and this prompt will be noted in the logbook.

E. The facilitator will be sure that the version of the tape being shown to the subject is the correct one (designated HJ or JH, as assigned in the master list).
and say, "This tape contains instructions that tell all you need to know to run the procedure. When you are ready, just press 'play'. You will be asked to put yourself in the place of a counselor or therapist working with the client on the tape. You will be asked to choose your responses from a set of three that will be shown on the screen. You will have 30 seconds to make your choice—this may seem short at times, so you need to be alert, and do the best you can without stopping the tape. Record your choice on this sheet (Appendix E). The tape will take about 45 minutes."

"The tape instructions ask for you to stop the tape between clients to complete a protocol—this doesn't apply to you—just keep the tape rolling. I will be outside if any difficulty comes up."

F. After the subject has completed the CTA procedure, the facilitator will thank the individual for their participation and inform them that the results of the study will be available when the dissertation study has been completed. Any comments by the subject will be recorded in the logbook.

G. If any of the subjects have sensory impairments, special accommodations will be made to facilitate the data collection process by the researcher.
Appendix H

Letter of Approval from Human Subjects
Institutional Review Board
TO: Scott T. Luppe
FROM: Ellen Page-Robin, Chair
RE: Research Protocol
DATE: May 8, 1989

This letter will serve as confirmation that your research protocol, "The Effects of Sex Role Orientation and Gender on Countertransference Behavior," has been approved as exempt by the HSIRB.

If you have any questions, please contact me at 387-2647.
BIBLIOGRAPHY


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