ABSTRACT

Title of Thesis: A TRIPARTITE MODEL OF THE THERAPEUTIC RELATIONSHIP: INTERRELATIONS AND SESSION OUTCOME

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The components of a tripartite model of the therapeutic relationship, namely the working alliance, the transference configuration, and the real relationship were examined in terms of how they relate to one another and to the outcome of a psychotherapy session. Licensed psychotherapists (n = 249) were recruited from two Divisions of the American Psychological Association. Therapists completed measures of the therapy relationship components and session outcome for the last session they had with a client. Results revealed that from the therapist's perspective the real relationship and working alliance related positively to session outcome, countertransference behavior related negatively to session outcome and transference did not relate to session outcome. The four components together contributed to 27 percent of the variance in session outcome. The components related to each other as predicted, and a principle components analysis revealed the presence of four distinct factors resembling the components of the tripartite model.

THE TRIPARTITE MODEL OF THE THERAPEUTIC RELATIONSHIP:

INTERRELATIONS AND SESSION OUTCOME

By

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Table of Contents

List of Tables

Chapter 1 - Introduction

The aim of the present study was to examine key components of the therapeutic relationship proposed by the tripartite model (Gelso & Samstag, 2008), namely the working alliance, transference, countertransference, and the real relationship, in terms of how they relate to each other and to session outcome. The construct of insight was studied as a moderator in the relationship between transference and session outcome. Furthermore, an exploratory factor analysis was conducted to study the underlying components of the therapy relationship. Using a correlational field study design, data were gathered on therapists' perceptions of the components of the therapeutic relationship, insight and session outcome for a single session with a client. Following previous literature (e.g., see review by Gelso & Samstag, 2008), it was hoped that the present study will replicate some earlier results, and at the same time bring all the components of the therapy relationship together to understand their association with session outcome and the interrelationships among them.

Gelso and Carter (1985) have defined the therapeutic relationship as, "the feelings and attitudes that counseling participants have toward one another, and the manner in which these are expressed" (p.159). Although the therapeutic relationship has been studied through decades, there remain gaps in literature that have not allowed us to grasp it very effectively in all its complexity. For many years understanding the therapeutic relationship entailed exploring what the therapist has to offer, rather than the client-therapist relationship (Rogers, 1957; Patterson, 1984). Lately its importance has been highlighted through a multitude of research (e.g. Wampold, 2010; Gelso & Hayes, 1998, Norcross, 2002, 2011). In fact, some psychotherapy outcome research has suggested that

specific therapy techniques are not major contributors to outcome when compared with the contributions linked to the therapy relationship (Lambert & Barley, 2002; Norcross & Lambert, 2011). These findings clearly highlight the importance of investigating unexplored parts of the therapeutic relationship. There exists limited data on the relationships among the components of the therapeutic relationship. The present study is an attempt to address and add to this realm of therapeutic relationship literature.

Gelso and Carter (1985) extended Greenson's (1967) psychoanalytic conceptualization of the components of the therapy relationship to all forms of counseling and psychotherapy, and not just psychoanalysis. Gelso and Samstag (2008) coined the term tripartite model to explain the components of the therapy relationship. Empirical research has largely indicated the presence of these components in all forms of psychotherapy and counseling. However, differences exist in the how much importance is given to each component in therapy work depending on the therapist's theoretical orientation. Gelso and Carter (1994) presented propositions on how the relationship components influence and are influenced by one another. The aim of the present study is to test some of the propositions offered by these authors. In the following section, the components of the therapy relationship will be explained briefly, followed by a description on how they are expected to emerge in the present study.

All the components of the tripartite model of the therapy relationship were examined in the present study. Working alliance is the most widely studied component of the therapy relationship. Gelso and Carter (1994) have defined the working alliance as, "the alignment or joining of the reasonable self or ego of the client and the therapist's analyzing or "therapizing" self or ego for the purpose of the work" (p.297). In his

conceptualization of the working alliance, Bordin (1979, 1994) described its features. These features included the client's presenting problem and treatment goals, the client and therapist agreement on effective therapeutic the goals of treatment and the tasks used to attain those goals, as well as the establishment of a bond that involves basic trust and confidence in the effectiveness of the therapeutic tasks and techniques.

Transference, as conceptualized by Freud, is reflective of the client's early experiences playing out in the later relationship with the therapist (1905/1953). Although transference has its roots in psychoanalytic theories, it is increasingly being recognized as a phenomenon present within all adult human relationships (e.g. Andersen & Glassman, 1996; Gelso & Hayes, 1998). Furthermore, therapists from varying schools of thought typically agree that clients manifest transference to some degree (Gelso & Bhatia, 2012; Woodhouse, Schlosser, Crook, Ligiéro, & Gelso, 2003). Stolorow, Brandshaft & Atwood (1987) have conceptualized transference as an intersubjective process, involving both the client and the therapist as participants. Seeking to integrate intersubjective theory with classical analytic theory, Gelso and Hayes (1998) have defined transference as "the client's experience of the therapist that is shaped by the client's own psychological structures and past and involves displacement onto the therapist, of feelings, attitudes, and behaviors belonging rightfully in earlier significant relationships" (p. 51).

Along with transference, the second component of the tripartite model (the transference-configuration) also includes countertransference. There has been considerable disagreement and differences in the conceptualization of countertransference. Recently, Gelso and Hayes (2007) aimed to bring the different perspectives together and defined countertransference as "the therapist's internal and

external reactions that are shaped by the therapist's past and present emotional conflicts and vulnerabilities" (p.25).

Lastly, Gelso and Samstag (2008) included the real relationship as a component of the therapeutic relationship in the tripartite model. Even though the idea of the real relationship has appeared in literature over the years, it is being studied empirically only off late. Greenson (1967) commented on the real relationship as being a fundamental aspect of all human relationships. In recent years, the work of Gelso and his colleagues (e.g. Gelso, Kivlighan, Busa-Knepp, Speigel, Ain, Hummel, Ma & Markin, 2012; Gelso, 2002, 2011; Gelso and Carter, 1985, 1994; Gelso and Hayes, 1998) has been significant in refining the concept of the real relationship. Gelso (2011) defines the real relationship as "The personal relationship existing between two or more persons as reflected in the degree to which each is genuine with the other and perceives the other in ways that befit the other" (p. 6). Due to the relatively recent interest in refining the concept of real relationship, there are only a few empirical studies associated with the concept.

One aspect of the present study examined the relationships among these components and session outcome. Session outcome was assessed by therapists' rating of the session quality, session depth and session evaluation. Of the components, working alliance is the most studied and there is a tremendous amount of support indicating its positive relationship with treatment outcome (e.g. Horvath, Del Re, Flückiger, & Symonds, 2011). In terms of transference, its association with treatment and session outcome is seen with insight as a moderator in the relationship (Gelso, Kivlighan, Wine, Jones & Freidman, 1997; Gelso, Hill & Kivlighan, 1991). Empirical data has lent support for insight as a moderator in the relationship between negative transference and treatment

outcome as well as session quality. That is, when client insight is high, negative transference relates positively to treatment outcome and session quality. Thus, the present study also examined insight, as the relationship between transference and session outcome seemed to be dependent on client insight.

Countertransference is seen to relate negatively to treatment outcome and session outcome (e.g. Hayes, Gelso & Hummel, 2011; Hayes, Riker, & Ingrim, 2007; Williams & Fauth, 2005). Both quantitative and qualitative evidence exists for this claim. In one study, Rosenberger and Hayes (2002) studied a single therapy dyad for 13 sessions and found that the patient's presentation of material relating to unresolved conflict in the therapist led to poorer evaluations of the session by the therapist. In another study, Williams and Fauth (2005) looked at in-session self-awareness of therapists. The authors found that therapist experience of stress in session (possibly indicative of countertransference) related to poorer evaluations of the session.

The real relationship is linked positively to treatment progress and treatment outcome (e.g. Ain & Gelso, 2011; Gelso, Kelley, Fuertes, Marmarosh, Holmes, Costa, & Hancock, 2005; Marmarosh, Gelso, Markin, Majors, Mallery & Choi, 2008; Fuertes, Mislowack, Brown, Gur-Arie, Wilkinson, & Gelso, 2007). Fuertes, Gelso, Owen, & Chen's (under review) recent study examined the real relationship across treatment of six therapy dyads. Results indicate that therapists perceive the real relationship to be strong at the beginning of treatment and that the real relationship continues to strengthen in successful cases. However, two recent studies indicated a lack of association between therapist ratings of the real relationship and therapist ratings of treatment outcome (Gelso et al., 2012; LoCoco et al., 2012). In the present study therapist ratings of the real

relationship and session outcome were examined to add to this literature, and perhaps explain the conflicting findings in terms of therapist ratings of the real relationship and outcome.

Despite existing research on the therapy components and their relationship to treatment outcome and session outcome, no study to date has examined all the components of the therapeutic relationship together. Thus, this study also aims to test how all the components relate *simultaneously* to session outcome. In other words, each component's unique contribution to session outcome will be examined.

The second part of the present study focused on the associations among the therapy components. There is a body of empirical literature, albeit limited, that has examined the components of the therapeutic relationship in order to understand the relationships that exist among them. A recent study by Gelso et al. (2005) examined the relationships among working alliance, transference, the real relationship and how they relate to session outcome. Therapist perceptions of the real relationship were found to correlate positively with the working alliance, the depth and smoothness of sessions, and therapists' ratings of both the intellectual and emotional insight displayed by the client. Furthermore results indicated a negative relationship between therapist-rated real relationship and negative transference. Other studies have shown a positive relationship between the real relationship, the working alliance and session progress (Fuertes et al., 2007) as well as a negative relationship between the real relationship and client transference (Fuertes et al., under review; Marmarosh et al., 2009).

In terms of other components, Patton, Kivlighan and Multon (1997) found that the working alliance appears to influence transference. Their study, using time-series

analysis, indicated that when the working alliance was high in a session, high levels of transference emerged in the following two sessions. Additionally therapists' countertransference is found to be negatively associated with the working alliance (Ligiero & Gelso, 2002).

The third part of the study entailed examining the factor structure underlying the measures of therapy relationship used in the present study. An exploratory factor analysis was conducted to assess how the items measuring the therapy relationship in this study group together, with the overarching aim of understanding how this factor structure makes sense in the context of the tripartite model. An exploratory factor analysis was used as opposed to a confirmatory factor analysis because no prior factor analyses had been conducted and we were uncertain as to how many factors would emerge from the items being analyzed. Results were expected to provide a nuanced understanding of the parts of the components that overlap or associate with one another.

In summary, components of the therapeutic relationship as posited by the tripartite model were studied in terms how they relate to each other, insight and session outcome. Data were gathered on therapist ratings of the working alliance, transference, client insight, countertransference, the real relationship and session outcome over a session with a single client.

Chapter 2 - Literature Review

The components of the therapeutic relationship proposed by Greenson (1967) in his treatise on classical psychoanalysis and psychoanalytic psychotherapy, and refined by Gelso and Samstag (2008) as the tripartite model, were examined in the present study. The components, namely the working alliance, transference-configuration (including transference and countertransference), and the real relationship, were studied in terms of how they relate to session outcome. Gelso and Carter (1994) proposed that the components of therapy relationship relate to each other in certain ways. In the present study some of these propositions were tested to add to the research in this realm.

The review of literature will focus on the therapeutic relationship, specifically its components as described by the tripartite model. A brief description and history of the components will be followed by a review of studies that have examined the therapy relationship components and their relation to session outcome and/or treatment outcome. Treatment outcome studies are included based on the premise that outcome of therapy relates to session outcome. The last section of this chapter will include findings on how the therapeutic relationship components are found to relate to each other.

The Therapeutic Relationship

The therapeutic relationship has been recognized over the years as a vital element of psychotherapy. Norcross (2011) has presented a detailed description of the role of the therapeutic relationship in therapy, its history and gaps in its literature. Norcross (2002) pointed out the omission of the therapy relationship in most evidence-based practice guidelines despite clinical experience and research indicating that the therapy relationship contributes towards much of the outcome variance.

Historically the roots of the psychotherapy relationship can be traced to the humanistic emphasis on the therapeutic relationship. The humanistic emphasis called for viewing the therapeutic relationship in terms of necessary and sufficient conditions, namely, empathic understanding, non-possessive warmth and positive regard, and congruence. Researchers have pointed out that in conceptualizing the therapy relationship in this manner, the focus lay more on what the therapist has to offer and less on the client- therapist relationship (Rogers, 1957; Patterson, 1984).

The therapeutic relationship is also connected to the psychoanalytic school of thought. The analytic conceptualization of the therapeutic relationship concerned itself with the components of transference, countertransference and the working alliance (Greenson, 1967).

Led by the surprising lack of a clear definition of the psychotherapy relationship, Gelso and Carter (1985) defined the therapeutic relationship as, "the feelings and attitudes that counseling participants have toward one another, and the manner in which these are expressed" (p.159). This definition of the therapy relationship has been adopted by Norcross in the two editions of his edited book (2002, 2011) on the therapeutic relationship. Lately a growing body of research has contributed towards highlighting the importance of the therapeutic relationship.

Research on the Therapeutic Relationship. Norcross (2002, 2011) highlights findings in psychotherapy outcome research. A body of research has indicated that specific therapy techniques are not a major contributor when compared with the contributions linked to the therapeutic relationship (Norcross & Lambert, 2011; Wampold & Brown, 2005; Lambert & Barley, 2002). This lends support to the

importance of the therapeutic relationship in all schools of therapy, although there are differences in the extent to which it is dealt with.

Keeping in mind the humanistic conceptualization of the therapeutic relationship, extensive research has been done on the humanistic factors of empathy, positive regard, and genuineness. Elliott, Bohart, Watson & Greenberg (2011) conducted a meta-analysis and found that empathy accounts for 9% of the variance in therapy outcome. Compared to Wampold's (2001) intervention effects in the range of 1% or 9%, it is seen that empathy accounts for more treatment outcome variance as compared to specific treatment methods. In terms of positive regard, Farber and Doolin (2011) presented meta-analytic findings, which indicated a moderate association between positive regard and psychotherapy outcome (aggregate effect size was found to be .27). Genuineness or congruence was found to account for approximately 6% of the variance in treatment outcome, with an overall effect size of .24, in a meta-analysis conducted by Kolden, Klein, Wang and Austin (2011).

The widespread agreement of the importance of therapeutic relationship led to researchers suggesting it have a place in the common factors approach (Duncan, Miller, Wampold & Hubble, 2010). Grencavage and Norcross (1990) reviewed 50 publications in order to recognize commonalities among proposed therapeutic common factors. They found the commonalities to be, development of a therapeutic alliance, opportunity for catharsis, acquisition and practice of new behaviors, and clients' positive expectancies, further adding support to the therapy relationship as a common factor in psychotherapy. More recently, Tracey, Lichtenberg, Goodyear, Claiborn and Wampold (2003) revisited Grencavage and Norcross's study in an effort to further reduce the number of

superordinate categories falling under the common factors approach, examine the relatedness among the specific commonalities, and provide an empirical basis for categorization of the common factors. Tracey et al. found two dimensions (processing and therapeutic activity) and three clusters (bond, information and role) guiding the conceptualization of common factors.

Despite the vast body of empirical research on the therapy relationship, some researchers view the concept of the therapeutic relationship as too general. One model that breaks it up and helps in understanding its components is the tripartite model (Gelso & Samstag, 2008). In the following section the therapeutic relationship as proposed by the tripartite model will be described briefly followed by a more in-depth look at the components of the therapy relationship.

The Tripartite Model of the Therapeutic Relationship

The tripartite model can be traced back to Greenson's psychoanalytic work in 1967. Greenson talked of the components of the therapy relationship; working alliance, transference, countertransference and the real relationship. Gelso and Samstag (2008) coined the term 'Tripartite Model' for the working alliance, transference configuration (including transference and countertransference) and the real relationship, which are now being recognized through a significant body of literature, in both psychoanalytic and non-psychoanalytic therapies. The definitions of these components are presented below.

Gelso and Carter (1994) have defined the working alliance as, "the alignment or joining of the reasonable self or ego of the client and the therapist's analyzing or "therapizing" self or ego for the purpose of the work" (p.297). In his work on the alliance, Bordin (1979, 1994) described the elements of the working alliance. These features

included the client's presenting problem and treatment goals, the client and therapist agreement on effective therapeutic tasks and techniques, and the establishment of a bond that involves basic trust and confidence in the effectiveness of the therapeutic tasks and techniques.

The second component of the therapy relationship as per the tripartite model is transference. It is defined by Gelso and Hayes (1998) as, "the client's experience of the therapist that is shaped by the client's own psychological structures and past and involves displacement onto the therapist, of feelings, attitudes, and behaviors belonging rightfully in earlier significant relationships" (p. 51).

Gelso and Samstag (2008) have reviewed four definitions of countertransference. The classical conception (S. Freud, 1912/1959) understands countertransference to be the therapist's unconscious reactions to the client's transference. The totalistic conception views countertransference as all of the therapist's emotional reactions to the client. Other theorists have emphasized on the interactive nature of countertransference. Gelso and Hayes (2007) aimed to bring the different perspectives of countertransference together and gave an integrative conception of countertransference. They defined countertransference as "the therapist's internal and external reactions that are shaped by the therapist's past and present emotional conflicts and vulnerabilities" (p.25).

The fourth component of the therapeutic relationship is the real relationship. Gelso's (2011) defined the real relationship as, "the personal relationship existing between two or more persons as reflected in the degree to which each is genuine with the other and perceives the other in ways that befit the other" (p.6).

This tripartite model is now being extended, in that the components of the psychotherapy relationship are being recognized in all therapies. Gelso and Carter (1985, 1994) posited the existence of the components, not just in psychoanalytic, but in all forms of therapies with differences in the ways in which they are dealt with. Furthermore, Gelso and Carter (1994) postulated that the components do not operate independently, instead interact with one another. For example, transference, and working alliance influence one another.

There are only a handful of empirical studies that examine how the components of the therapy relationship relate to one another (e.g. Fuertes, Gelso, Owen, & Chen, under review; Gelso, Kelley, Fuertes, Marmarosh, Holmes, Costa, & Hancock, 2005; Marmarosh, Gelso, Markin, Majors, Mallery & Choi 2009; LoCoco, Gullo, Prestano, & Gelso, 2011). Through the present study, certain gaps in literature pertaining to the components of the tripartite model were addressed. In the following sections, a review of the components of the therapy relationship is presented.

Working Alliance

As with most other components of the therapy relationship, the concept of working alliance originated with Freud (1912, 1913). Though Freud did not talk about the term ‘alliance’ he did elaborate on the reality based collaboration between therapist and the client (Horvath, Del Re, Flückiger, & Symonds, 2011). Horvath et al. talk of Sterba, Zetzel and Greenson’s contributions towards defining the working alliance. Sterba (1934) coined the term ego alliance to capture the client’s ego-observing process. The term therapeutic alliance originated with Zetzel (1956) to describe the client’s tendency to use

his/her healthy part of the ego to join with the analyst. Greenson (1965, 1967) talked of the working alliance as the client's ability to align with therapeutic tasks.

Moving away from the analytic conceptions of the working alliance, Luborsky (1976) gave a more general description of the alliance. This line of thought was further refined by Bordin (1975,1989,1994). Bordin contributed immensely to the concept of working alliance. As indicated previously, he talked of three features of the working alliance; agreement on the therapeutic goals, consensus on the therapeutic tasks, and a bond between the client and the therapist. Based on more recent work (Bordin, 1980; Hatcher, Barends, Hansell & Gutfreund, 1995; Luborsky, 1976), the working alliance now refers to the active collaboration between the therapist and the client as opposed to unconscious distortions of the therapeutic relationship. Much of what we know about the working alliance depends on the nature of its definition and measures. The following section briefly highlights some of the most used measures of the working alliance.

Measuring the Alliance. Even though there are over 30 alliance measures that exist, meta-analysis results have highlighted four core measures (Horvath et al., 2011). These are California Psychotherapy Alliance Scale (CALPAS, Gaston & Marmar, 1994), Helping Alliance Questionnaires (HAQ, Alexander & Luborsky, 1986), Vanderbilt Psychotherapy Process Scale (VPSS, O'Mally, Suh & Stupp, 1983) and Working Alliance Inventory (WAI, Horvath & Greenberg, 1986). Three of these (WAI, CALPAS, and HAQ) are found to share the concept of 'confident collaborative relationship" as a central theme (Hatcher et al., 1995; Hatcher & Barends, 1996). The four measures mentioned here have been utilized over the course of 20 years and have evolved through the years. They are found to have acceptable levels of internal consistency. In the present

study therapists' ratings on the WAI- Short form were used, as its conceptualization of the working alliance and easy use made it most fitting for this study.

Related Research on the Working Alliance. The working alliance is the most studied component of the therapy relationship (Gelso and Samstag, 2008). The present review will focus on the relationship between the working alliance and treatment outcome as well as session outcome. Meta-analyses of studies on the working alliance will be used to shed light on these two domains, coupled with individual studies that help illustrate the results obtained from the meta-analyses. Horvath et al. (2011) conducted meta-analyses of studies on the therapeutic alliance. In their meta-analyses they included studies that met the following criteria; authors referred to the therapy process variable as alliance (including variants of the term), studies that were based on clinical (not analog) data, studies that had more than five participants, and studies that reported data that could be used to extract or estimate values indicative of the relationship between alliance and outcome

Horvath et al. (2011) used a random effects model for their analysis and found an aggregate effect size for 190 independent alliance-outcome relations representing over 14,000 treatments to be moderate but reliable ($r = .275$, $p<.00001$). This value was in tune with previous meta-analytic findings (Horvath & Bedi, 2002, r=.21, k=100; Horvath & Symonds, 1991, r = .26, k=26; Martin, Garske, & Davis, 2000, r=.22, k=79). Horvath et al. (2011) conclude a robust overall relation between alliance and outcome in individual therapy, accounting for approximately 7.5% of the variance in treatment outcomes.

Dereubis, Brotman & Gibbons (2005) have pointed out that in order to understand the statistical relationship between alliance and outcome, we need to examine the sources of variation in the alliance. They put forth four possible sources: the therapist, the client, their interaction (in the statistical sense), and symptom improvement. There have been differing results in the contribution of therapist and client effects on the working alliance and to the therapy outcome. Baldwin , Wampold & Imel (2007) used multilevel modeling to examine the relative importance of patient and therapist variability in the alliance as they relate to outcome, and found that therapist variability in the alliance predicted outcome, whereas patient variability in the alliance did not relate to outcome.

In recent years the association of working alliance and outcome has been studied in psychodynamic therapies, as well as theoretically heterogeneous therapies. A study by Gaston, Goldfried, Greenberg, Horvath, Raue & Watson (1995) lent support for the relationship between working alliance and outcome in cognitive therapy, behavior therapy and brief dynamic therapy. The authors studied depressed elderly patients treated in these three forms of therapy and examined the prediction of outcome by alliance, technique (exploratory and supportive), and their interactions. Results indicated that in behavior therapy, pre-therapy depression levels and alliance predicted outcome. In cognitive therapy, both alliance and exploratory interventions predicted outcome throughout the course of treatment and in brief dynamic therapy, some alliance dimensions predicted outcome throughout treatment, and exploratory interventions predicted outcome mid therapy. Although the study provided support for the alliance and outcome in different types of therapy, it also highlighted the presence of differential processes across therapy conditions and phases.

Along with the association between working alliance and treatment outcome, there is also evidence for associations between working alliance and session outcome. Pesale (2011) studied patient rated early session outcome and its relationship to treatment outcome. Results indicated that session evaluation ratings as measured by Session Evaluation Questionnaire's Positivity scale (Stiles & Snow, 1984) related positively to patient rated improvement in global functioning. When therapist effects were accounted for, patient-rated working alliance mediated this positive relationship between session outcome and improvement in global functioning. There are other studies that throw some light in the realm of alliance and session outcome. For example, in studies on the working alliance and complementarity, results have indicated the presence of a meaningful relationship between quality of alliance and harmonious (friendly and autonomy-enhancing) versus competitive (hostile or controlling) interaction (Kiesler & Watkins; Tracey & Ray, 1984). In other words, harmonious, positive interactions are associated with a strong working alliance.

Lastly, the significance of working alliance in therapy is also indicated in studies that have looked at alliance as a predictor of premature termination (e.g. Arnow et al, 2007; Johansson & Eklund, 2006; Kokotovic & Tracey, 1990; Mohl, Martinez, Ticknor & Huang, 1991). Sharf, Primavera & Diener (2010) conducted a meta-analysis of 11 studies that have examined the relationship between psychotherapy dropout and therapeutic alliance. Results indicated a moderately strong relationship between the two (d= .55), thus providing support for the hypothesis that a weaker alliance can predict premature termination.

In summary, the working alliance is the most studied component of the tripartite model. Its history is rich and marks its evolution through the years. At present, there is a large body of research that provides support for its association with treatment and session outcome.

Transference

Through the years, there have been controversies in defining transference. A major current source of this controversy involves the extent to which transference entails co-construction between the therapist and the client, and distortion of the therapist. Perhaps because of its complex nature, defining transference has been a struggle, with researchers offering varying definitions. In the following section three major conceptualizations of transference are presented.

The rich history of transference can be traced back to 1888, when Freud first talked of it. Freud elaborated on the concept of transference in 1905 to explain a therapeutic failure in his analysis of Dora. In 1912, Freud talked of transference as a universal phenomenon and proposed the role of transference as a central mechanism of therapeutic change. Gelso and Hayes (1998) have noted that Freud viewed transference as a template that guides future relationships. Although classical Freudian theory viewed transference largely as a transfer of the client's material rooted in the Oedipal stage onto the therapist (E. Singer, 1970), later interpersonal theorists such as Sullivan (1954) and Fromm-Reichmann (1950) broadened the definition to include a displacement of feelings, attitudes and behaviors rooted in early relationships onto the therapist. An important component of these conceptualizations of transference involved distortion of the therapist. A more recent view of transference stems from postmodern constructivist

thought (Rabin, 1995). Here, transference is conceptualized as an intersubjective process, contributed to by the client as well as the therapist. Stolorow and Lachmann (1984/1985), proponents of this view, define transference as, "all the ways in which the patient's experience of the analytic relationship is shaped by his own psychological structures- by the distinctive, archaically rooted configurations of self and object that unconsciously organize his subjective universe" (p.26). Although advantageous in that the intersubjective view emphasizes collaboration, it has been criticized for being too broad (Gelso and Hayes, 1998). Gelso and Hayes attempt to bring these different conceptualizations of transference together, while addressing their disadvantages in their definition of transference as " the client's experience of the therapist that is shaped by the client's own psychological structures and past and involves displacement, onto the therapist, of feelings, attitudes, and behaviors belonging rightfully in earlier significant relationships" (p.51).

Differing definitions and conceptualizations of transference have led to varying methods of measuring the construct. The following section will briefly examine some modes of measuring transference used in recent research.

Measuring Transference. Due to the complex nature of transference and difficulties in defining the construct, there are differing ways of measuring transference that have been developed. Measures of transference can broadly be classified into three clusters: observer-rated, client-rated and therapist-rated (Gelso and Samstag, 2008). These three areas of measuring transference are reviewed briefly.

Early research on transference measured the construct using observer ratings. Two such measures that were used repeatedly were Core Conflictual Relationship Theme

method (CCRT; Luborsky & Crits-Cristoph, 1998) and the Plan Formulation Method (PFM; Curtis & Silberschatz, Weiss & Sampson, 1994). The premise of these measures lies on reliable observers rating the client's characteristic patterns of relationships based on the client's descriptions of their interactions with others. Patterns of relationships would then serve as predictors to or proxies of the type of transferences emerging in the course of therapy (Gelso and Samstag, 2008). These methods have been advantageous in addressing the complex nature of therapy. However, this advantage also doubles as a weakness, wherein the complex nature of these measures makes their use time consuming. Another disadvantage of this approach lies in the absence of a transference score. Lastly the approach also faces critique, as it tends to be challenging for observers to learn, thereby tending to involve small samples and limiting generalizability (Gelso and Samstag, 2008).

Another method of measuring transference is through client ratings. The Central Relationship Questionnaire (CRQ) was developed by Barber, Foltz and Weinryb (1998) as a measure of self-reported characteristic interactions with significant others. The CRQ shares components with the CCRT, e.g. client's expected responses of self and others. Expectedly, the utility of self-reported measures lies in its relatively easy use. However, client-rated transference measures are criticized as not capturing essential elements of transference that lie in the client's unconscious and may result in distortion of the therapist.

Lastly, transference can be measured through therapist ratings. Examples of two such measures that have been developed to allow therapists to rate their client's transference are The Missouri Identifying Transference Scale (MITS; Multon, Patton, &

Kivlighan, 1996) and Graff and Luborsky's (1977) Therapy Session Checklist-Transference items. Both these measures are found to have acceptable reliability and validity evidence (a detailed description of the reliability and validity evidence for Therapy Session Checklist- Transference items is presented in the Method chapter). Though similar to client ratings of transference (therapist-rated measures are easy to use), there exist certain disadvantages as well. Gelso and Samstag (2008) have pointed out that such measures may be at risk of therapist biases, which may cause them to selectively attend to certain client features based on their own histories. Despite difficulties, therapist-rated transference has been used in a number of studies and results have indicated acceptable reliability and validity evidence. Therapist-rated transference was used as a measure of client transference to the therapist in the present study. The next section of the review focuses on empirical studies on transference that will shed light on its conception in the present study.

Related Research on Transference. This section on the review of transference will focus on two lines of research. The first will look at studies that have contributed to the evidence of the presence of transference in heterogeneous theoretical orientations. As mentioned previously, the notion of transference finds its roots in psychodynamic therapy. Although a large part of the research on transference has focused on dynamic therapy, there is a small body of empirical data that examines transference in non-dynamic therapies. These studies will be reviewed in light of the present study, which examines transference in heterogeneous forms of therapy. Secondly, this section will review studies that highlight the association of transference with treatment and session outcome.

At present there are some efforts to bring perspectives together in understanding transference as present in heterogeneous forms of therapy. Woodhouse et al. (2003) have talked of therapists from varying schools of thought agreeing on the presence of transference. Differences lie in whether they decide to work with that transference and the ways in which they work with it. Gelso and Hayes (1998) have stated, "to varying degrees, transference occurs and affects process and outcome in all psychotherapies, regardless of theoretical orientation" (p. 68).

In their paper on the presence of transference in non-dynamic therapies, Gelso and Bhatia (2012) note that transference has been talked of by non-analytic theorists such as Carl Rogers (1951), Fritz Perls (1958) and current feminist and multicultural theoreticians, such as Laura Brown (1994) and Jennifer Kelly and Beverly Greene (2010). Furthermore, Gelso and Bhatia (2012) have reviewed 16 empirical studies, that have contributed to the proposition that transference exists in almost all major forms of therapy (e.g. Arachtingi & Lichtenberg, 1999; Beach & Power, 1996; Connolly, Crits-Cristoph, Demorest, Azarian, Muenz, & Chittams, 1996; Horowitz & Moller, 2009; Gelso, Hill & Kivlighan, 1991; Gelso, Kelley, Fuertes, Marmarosh, Holmes, Costa, & Hancock, 2005) . Gelso et al,'s (2005) study indicated a modest relationship (in the .20s) between psychoanalytic orientation and therapists' ratings of the amount of positive and negative transference. Moreover, when given a definition of transference and asked to rate its manifestation in their work, non-analytic (CBT and humanistic/experiential) therapists did not differ in their perceptions of transference, indicating that allegiance with non-analytic orientations does not suggest that therapists' see less transference.

These findings provide support for using a theoretically heterogeneous sample to rate transference.

Along with research on transference and non-analytic therapies, it is relevant here to examine research on transference and how it relates to session outcome and/or treatment outcome. Findings indicate that therapist-rated transference is negatively associated with 'session smoothness' (Gelso et al., 2005). However, there have been mixed findings in understanding the association between transference and treatment outcome. Gelso, Kivlighan, Wine, Jones & Freidman (1997) found that the intensity or amount of transference was unrelated to outcome, however results of another study indicated that intensity or amount of transference related negatively to symptom change (Marmarosh et al., 2009). This finding was especially true for negative transference in that it predicted less symptom change.

A replicated finding in the realm of transference and session outcome studies is that insight appears to moderate the relationship between transference and session outcome. Before summarizing the results of these studies, it may be helpful to clarify what is meant by insight, especially how these studies conceptualized the construct. Insight here is defined by as:

"Extent to which client displays accurate understanding of material being explored. Understanding may be of the relationship, client's functioning outside of counseling, or aspects of the client's dynamics and behavior. Intellectual insight reflects an understanding of the cause-effect relationships but lacks depth because it does not connect to affects underlying client's thoughts. Emotional insight connects affect and

intellect; the client is thus connected emotionally to his or her understanding" (Gelso, Hill & Kivlighan, 1991, p. 3).

It is important to note here the distinction between emotional and intellectual insight. Furthermore, insight as conceptualized in the present study (and this definition) refers to client's general self-insight as opposed to the client's insight into transference. It is assumed that general self-insight will contribute to client's understanding of transferential responses as well (Gelso et al., 1997). At this point, insight will not be reviewed further as it is not a variable of central interest, instead its relation to transference and treatment outcome and session outcome will be examined through the following studies.

Gelso et al. (1997) conducted a study where they obtained insight, transference and counseling outcome ratings from 33 completed cases. The data was analyzed for the first session and first quarter of treatment in predicting treatment outcome as well as understanding the relation (if any) between therapist rated transference and insight in more and less successful cases. The results of the study indicated that transference interacted with the client's level of emotional insight in predicting outcome. This means that when insight was low, transference (especially negative transference) was less likely to relate to session outcome, whereas when insight was high, transference related positively to session outcome. Thus, transference (especially negative transference) appeared to be particularly beneficial when therapist perceived their clients as having greater amounts of emotional insight. This finding was previously seen in a study by Gelso, Hill, Kivlighan (1991). The authors examined single sessions of 38 experienced

therapists and found insight to moderate the relationship between transference and session quality in ways similar to those found in the Gelso et al. (1997) study.

These studies were both based on ratings of transference and insight by a theoretically heterogeneous sample of therapists, lending support for the generalizability of the results to a diverse sample of therapists in terms of their theoretical orientation. Furthermore, these findings point to the importance of understanding how transference, especially negative transference can have both, a positive or negative impact on therapy, depending on whether the client gains or lacks insight in therapy.

Countertransference

Traced back to Freud, the construct of countertransference has been defined in differing ways through the years. Gelso and Hayes (2007) add to the three conceptions of countertransference put forth by Epstein and Feiner (1988) and present the five following definitions of countertransference.

The Classical View originated with Freud (1910/1959) and was strengthened later by Annie Reich (1951, 1960). The classical view explains countertransference as the therapist's transference to the patient's transference. This means that unresolved conflicts traced back to the therapist's childhood are triggered by the client's transference. The classical view received criticism in light of it being too narrow (Epstein & Feiner, 1979; Gelso & Hayes, 1998).

The Totalistic view of countertransference emerged in the 1950s. It conceptualizes all of the therapist's attitudes and feelings towards the patient as countertransference. Through this view, the therapist's emotional experience became a highly significant and

vital part of the psychodynamic work (Gelso and Hayes, 2007). Despite its many advantages, the totalistic view is criticized for being too broad.

The Complementary view, put forth by Epstein and Feiner (1988), considers countertransference to be the complement or counterpart to the way the patient tends to relate to others, or his/her transference (Gelso & Hayes, 2007). The therapist and the patient constantly affect and influence each other through the course of treatment. A key advantage of this view lies in its inclusion of the interpersonal aspect of countertransference (Gelso, 2004). However, Gelso also points out that its shortcoming lies in the lack of emphasis placed on the therapist's internal world as a causal factor.

The Relational view adds to the complementary view by including therapist's contribution in the interactive nature of countertransference (Gelso, 2004). Gelso and Hayes (2007) presented their conception of an *integrative view* of countertransference as containing elements of the previous four views on countertransference. They have defined countertransference as "the therapist's internal and external reactions that are shaped by the therapist's past and present emotional conflicts and vulnerabilities" (p.25). The present study will rely on the integrative view of countertransference.

Along with psychoanalytic theories, the concept of countertransference has also been theorized by rational-emotive therapy (Ellis, 2001), feminist social constructionism (Brown, 2001), constructive brief therapy (Hoyt, 2001), interpersonal therapy (Kiesler, 1996), couples and family therapy (Kaslow, 2001), and experiential perspective (Mahrer, 2001).

Keeping in mind the present study, the review on countertransference will focus on its relation to session and treatment outcome. Before moving to the review, however, it is relevant to briefly describe the process of measuring countertransference.

Measuring Countertransference. Unsurprisingly measures of countertransference reflect the way it is defined. Despite the differing definitions of countertransference, there seems to be a general agreement, where measures attempt to tap into the therapist's unresolved conflict most likely triggered by certain patient characteristics (Hayes et al., 2011). Countertransference measures exist to measure countertransference emotions (e.g. The State Anxiety Inventory, Hayes & Gelso, 1991, 1993; Therapist Appraisal Questionnaire, Fauth & Hayes, 2006), countertransference behaviors (The Index of Countertransference Behavior, Freidman & Gelso, 2000; Countertransference Behavior Measure, Mohr, Gelso & Hill, 2005) and countertransference management (e.g. Countertransference Factors Inventory, VanWagoner, Gelso, Hayes & Deimer, 1991). Along with these three areas of countertransference measures, differences also lie in who completes the ratings. Both self-reports and rater or clinical supervisors' assessments can be used to measure CT. The present study will use self-reported scores on the ICB as a measure of countertransference behavior. The rationale for using therapist-rated countertransference is presented in the method chapter.

Research on Countertransference and Therapy Process/Outcome. The present study will examine the association between countertransference and session outcome. In that vein, this section will review the literature on countertransference and session as well as treatment outcome.

Singer and Luborsky (1977) reviewed research on countertransference and concluded that uncontrolled countertransference related negatively to therapy outcome. They talked of uncontrolled countertransference as having an adverse influence on therapist's techniques, interventions and understanding of the client. Through the years, research has generally corroborated Singer and Luborsky's conclusion. In a review of empirical research on countertransference Hayes (2004) concluded that a number of studies have indicated that therapists often fail to maintain an appropriate therapeutic distance with patients at a behavioral level with the activation of countertransference. Most often, this disturbance in appropriate therapeutic distance is manifested as avoidance behavior (e.g. Bandura et al., 1960; Cutler, 1958; Gelso, Fassinger, Gomez & Latts, 1995; Hayes & Gelso, 1991, 1993; Robbins & Jolkovski, 1987).

Hayes, Gelso and Hummel (2011) carried out a meta-analysis of studies on countertransference in relation to psychotherapy outcome. In their meta-analysis they examined articles and dissertations that included at least two of the three variables: countertransference, countertransference management, and psychotherapy outcome. In presenting their findings, the authors distinguished between treatment outcomes that exist on a continuum; a) immediate outcomes referring to effects within the session, b) distal outcomes referring to treatment effects at the end of treatment or following termination and c) proximal outcomes involving those relating to a given session or series of sessions. For 10 quantitative studies, meta-analytic findings indicated a modest negative relationship between countertransference and outcome. The average weighted r of countertransference with outcome was found to be -.16 with a 95% confidence interval of -.26 to .06. Results also indicated an interaction effect, where distal outcomes had a

higher average r (r=-.36; 95% confidence interval: -.40 to -.32) in comparison to proximal outcome studies (r=-.09; 95% confidence interval: -.18 to .01).

Looking at individual studies on countertransference and session/treatment outcome will further highlight the results of this meta-analysis. Cutler (1958) was one of the first to study countertransference and its effects on therapy. The work of two therapist trainees and their supervisors' judgments were studied. Results indicated that supervisors evaluated therapist interventions as less effective in instances where the patient presented material, which translated into unresolved conflict in the therapists.

Hayes, Riker and Ingrim (1997) studied 20 counseling dyads involving therapist trainees. Both the counselors as well as their supervisors rated countertransference for each session. The authors found that countertransference behavior related negatively to treatment impact in less successful cases (supervisor r = -.87; counselor r =-.69). No association was seen between countertransference behavior and treatment impact in successful cases. The authors have suggested that in more successful cases, countertransference is managed in ways where its presence is unrelated to treatment results.

Williams and Fauth (2005) looked at in session self-awareness of therapists. The authors found that therapist experience of stress in session related to poorer evaluations of the session. Hayes et al. (2011) included this study in their meta-analysis based on the assumption that stress in the session is indicative of countertransference emotions.

Along with quantitative studies, there are a handful of qualitative studies that have contributed to the literature on countertransference and therapy outcome. In a case study of 13 therapy sessions, Ronsenberger & Hayes (2002) found that the patient's

presentation of material relating to unresolved conflict in the therapist led to poorer evaluations of the session by the therapist.

Lending support to the postulate that countertransference is present in all forms of therapy, a qualitative study (Hill, Nutt-Williams, Heaton, Thompson, & Rhodes, 1996) studied 12 experienced therapists of heterogeneous theoretical orientations in order to look at factors that cause disagreements between clients and therapists and result in termination. Each of the therapists reported one case where an impasse or disagreement had led to the end of therapy. Countertransference was found to be one of the most prominent amongst the many factors that were associated with the impasse.

Two qualitative studies have suggested the universality of countertransference reactions. Gelso, Hill, Mohr, Rochlen & Zach (1999) interviewed eleven experienced psychodynamic therapists to study their reactions to transference in successful long-term cases. The interviews yielded responses where despite the success of the cases, therapists reported instances of countertransference. Hayes, McCracken, McClanahan, Hill, Harp, & Carozzoni (1998) studied eight experienced therapists in their treatment of one patient for sessions raging from 12 to 20. The authors found that not only was countertransference identified by therapists in 80% of their 127 sessions, it also was prominent in each case. Hayes et al. (2011) have suggested the implication of this finding in understanding countertransference as a universal phenomenon in therapy.

In conclusion, these results indicate that countertransference has a modest negative association with treatment as well as session outcome. However appropriate countertransference management is associated with success in treatment. Furthermore,

this review suggests the presence of countertransference in therapies of different theoretical orientations.

The Real Relationship

The last component of the therapeutic relationship being examined in the present study is the real relationship. Looking back at its history, it is seen that the real relationship has existed as an elusive entity, appearing in the writings of leading psychoanalysts, but not explicitly defined by them. In his book on the real relationship, Gelso (2011) has talked of Freud allowing a reality element into the therapy relationship with the Wolf-man. Some analysts (e.g. Menaker, 1942; Freud, 1954) have distinguished between what is realistic and what is transferential in the therapy relationship. Greenson (1965, 1967) was the one of the first to explore the real relationship in more detail. The real relationship as conceptualized by Greenson included elements of authenticity, genuineness and realism in the analyst in both behaving and being with the patient.

Apart from psychoanalytic thought, the real relationship has also appeared in other approaches. For example, in humanistic therapies the genuineness component of the real relationship is a key element (Gelso, 2011). Rogers (1957) included genuineness in the three necessary and sufficient conditions to be possessed by therapists for change to occur.

Following Greenson, a number of psychoanalysts worked on examining the concept of the real relationship. More recently, Gelso and his colleagues (e.g. Fuertes et al., under review; Gelso et al., 2012; Ain & Gelso, 2011; Gelso, 2011; Marmarosh et al., 2009, Fuertes et al., 2007, LoCoco et al., 2011) have contributed to our understanding of the concept. As mentioned previously Gelso (2011) has defined the real relationship as

"the personal relationship existing between two or more persons as reflected in the degree to which each is genuine with the other and perceives the other in ways that befit the other" (p.6). Gelso has posited the real relationship to consist of two key elements. The first, genuineness is defined as, "being authentic or who one truly is as opposed to being phony or fake" (p. 13). The second, realism is "experiencing and perceiving the other in ways that befit the other rather than on ways that fit what the perceiver wishes for, needs, or fears" (p.13). Through their work on the real relationship, Gelso and his collaborators posited two additional concepts to further refine the concept; magnitude and valence of the real relationship. Magnitude indicates how much of a real relationship exists at any given point. Valence captures the extent to which the therapists' and patients' feeling and thoughts that constitute their real relationship are positive or negative. Gelso believes positive valences to be indicators of a strong real relationship. This point of view was questioned, in that a strong real relationship should allow for negative feelings and emotions on part of the patient (McCullough, 2009). Gelso has responded to this argument by stating, "The real relationship needs to be positively valenced overall, and this positive valence allows for negative feelings on the patient's part to come to the surface and to be resolved" (p.63).

A key concern in the conception of the real relationship is whether it exists as a separate variable in the psychotherapy as opposed to being enmeshed with the other components of the therapy relationship. There is a considerable body of literature that has provided support for the existence of the real relationship as a unique variable. Before examining this research it makes sense to understand how the real relationship is assessed and measures that exist for the real relationship at present.

Measuring the Real Relationship. There are three measures of the real relationship that exist to date (Eugster and Wampold, 1996; Gelso et al., 2005; Kelley, Gelso, Fuertes, Marmarosh, & Lanier, 2010). The measure of the real relationship put forth by Eugster and Wampold (1996) was part of a battery of measures, where the real relationship construct involved eight items to be rated by the therapist and eight items by the client (Gelso, 2011). Gelso pointed out that the items tended to lean on the genuineness aspect and lacked emphasis on the realism aspect of the real relationship. There seemed to be marginal reliability (patient ratings Cronbach's alpha=.66, therapist ratings Cronbach's alpha= .72) evidence for the measure.

Gelso et al. (2005) created the therapist version of the Real Relationship Inventory (RRI-T), based on theoretical conceptions of Gelso and Carter (1985, 1994) and Gelso and Hayes (1998). The scale consists of 24 items, and two subscales; Genuineness and Realism. Alpha coefficients for the Realism subscale, Genuineness Scale and total score were found to be .89, .87 and .93. Along with reliability, results indicated support for convergent validity, discriminant validity (see Gelso et al, 2005 for more details). The present study will use the therapist version of the real relationship in assessing therapists' perceptions of the real relationship.

Kelley et al. (2010) developed the client version of the Real Relationship Inventory (RRI-C). Similar to the therapist form, the client form consists of 24 items and two subscales, Genuineness subscale and Realism subscale. Results of the measure development study indicate support for the reliability and validity of the measure. Alpha coefficients for the Realism subscale, Genuineness Scale and total score were found to be .90, .91 and .95.

Research on the real relationship exists in its nascent stages. These client and therapist measures of the real relationship have been used to validate the existence of real relationship as a construct and add to our understanding of the construct. The following section will review related research on the real relationship

Related Research on the Real Relationship. In light of the present study, in this section, review of research on the real relationship will focus on its association with session outcome as well as treatment outcome. Results of a few studies reveal a positive association between the real relationship and session outcome. The earliest empirical study on the real relationship was carried out by Eugster and Wampold (1996). They examined process components that predict evaluation of psychotherapy sessions, in both therapists and clients. Results indicated that the patient and therapist ratings of the real relationship had a significant relationship with patient and therapist evaluations of one of their sessions. In another study, Gelso et al. (2005) examined the perceptions of 88 therapists' real relationship with a given client and found that therapists' ratings of their strength of the real relationship with a given patient were positively related to the depth ($r=.36$) and smoothness ($r=.43$) of sessions.

Other studies have corroborated similar findings in relation to the real relationship and therapy progress as well as outcome. Ain and Gelso (2011) studied 61 therapist-client dyads and found the real relationship to relate to treatment progress positively, from both the client's and therapist's perspective (therapist ratings of the real relationship and treatment progress, $r=.41$, $p<.01$; client ratings of the real relationship and treatment progress, $r=.64$, $p<.01$). Fuertes, Mislowack, Brown, Gur-Arie, Wilkinson, & Gelso (2007) found similar results in their study of 59 psychotherapy dyads (for therapist

ratings of real relationship and progress r= .49, p< .001; for patient ratings of real relationship and progress r= .36, p<.001).

Marmarosh et al. (2009) studied 31 therapy dyads at a university counseling center in order to examine the relationship between the real relationship and treatment outcome. They did so by assessing the real relationship in the third session of therapy and at terminations and symptom ratings at the beginning and the end of treatment. They found that therapist rated real relationship after the third session was significantly associated with treatment outcome (symptom change) (r=.58, p<.01). It is relevant to note here, that unlike other studies (Fuertes et al., 2007; Ain & Gelso, 2008; Ain & Gelso, 2011) Marmarosh et al.'s (2009) study found no support for a relationship between patient ratings of the real relationship and treatment outcome.

LoCoco et al. (2011) conducted a study similar to Marmarosh and her collaborators (2009) in a university counseling center in Sicily, Italy. They reported somewhat different findings. Their results did not replicate Marmarosh et al.'s (2009) finding of therapist rated real relationship relating to treatment outcome. They did find however, a significant relationship between client ratings of the genuineness aspect of the real relationship after the third session and treatment outcome (r=.26, p<.05). Furthermore, client ratings of the real relationship following the 8th session correlated with treatment outcome (r=.52, p<.01). This finding is similar to that found by Spiegel et al. (2008) in their study of 28 therapist-client dyads. Results indicated that overall client ratings of the real relationship at the end of treatment correlated with treatment outcome (r=.56, p<.001).

Similar to LoCoco et al. (2011), Gelso et al. (2012) studied 42 therapy dyads and did not find therapist ratings of the real relationship to relate to treatment outcome, whereas they did find client ratings of the real relationship to be positively associated with treatment outcome. However, Gelso et al. looked at how the real relationship unfolds over the course of therapy and found that an increase in the strength of the real relationship over time from the therapist's perspective did relate positively to outcome.

In conclusion, a small but growing body of research has examined the relationship between the real relationship and treatment outcome as well as session outcome. Even though there are some conflicting findings, there seems to be some evidence of a positive relationship between the real relationship and session/treatment outcome.

Relationships Among the Therapeutic Components

Gelso and Carter (1994) were the first to talk about the relationship among the therapeutic components. They postulated that in all forms of psychotherapy the components of the therapy relationship do not operate independently of one another. Instead they work together, often influencing and merging into each other. These authors further offered propositions, some of which have been tested empirically. Gelso and Carter's propositions that are relevant to the present study are presented briefly followed by a review of the key findings.

The Working Alliance and Transference. Gelso and Carter theorized that transference and the working alliance mutually influence one another. They proposed that positive transference tends to strengthen the alliance whereas negative transference tends to weaken it.

There seems to be support for this proposition. Although not studied extensively,

there are studies that have examined the relationship between transference and working alliance (e.g. Marmarosh et al., 2009; Patton, Kivlighan & Multon, 1997). Patton et al. used a short-term psychoanalytic counseling model to study six counselors seeing 16 clients over the course of two semesters. Results indicated that the working alliance increased as sessions progressed. In relation to transference, the authors found that working alliance seemed to influence transference although transference did not influence the alliance. Marmarosh et al. found a negative relationship between therapist-rated working alliance and therapist-rated negative transference ($r=-.44$, $p< .01$). It is hoped that the findings of the present study add to these studies in understanding the association between working alliance and transference.

The Working Alliance and Countertransference. Gelso and Carter (1994) have talked of the relationship between working alliance and countertransference as similar to that of transference and the working alliance. Empirical evidence has indicated a negative relationship between therapist's countertransference and the working alliance. Ligiero and Gelso (2002) studied 50 therapists in their work with a given client. Therapists' filled out ratings of working alliance with a client and their supervisors rated therapists' working alliance and countertransference with the same client. Results indicated a negative correlation between negative countertransference and the working alliance ($r=-.34$, $p<.01$) and a negative association between supervisor ratings of positive countertransference and the bond aspect of the working alliance ($r=-.36$, $p<.01$).

Rosenberger and Hayes (2002) analysis of a single therapy dyad for 13 sessions yielded findings that differed from Ligiero and Gelso (2002). They found that countertransference did not relate to the working alliance, although therapist ratings of

countertransference management related positively client rated working alliance. The authors reasoned that countertransference management might play a small role in fostering the alliance. Furthermore, the therapist in Rosenberger and Hayes' study had high countertransference management ratings implying that low countertransference behaviors might not impact a strong working alliance.

The Working Alliance and the Real Relationship. Gelso and Carter theorized a positive association between the working alliance and the real relationship. Moreover, they hypothesized that the working alliance influences the real relationship in that a stronger alliance will lead to more genuine and realistic feelings in the counseling dyads. Recent studies on the real relationship have supported this hypothesis. Fuertes et al. (under review) studied six therapy dyads and found that the real relationship and the working alliance unfolded similarly from the therapist's perspective in successful dyads. They found that both the working alliance and real relationship start of strong at the beginning of treatment and continue to increase, from the therapist's perspective in the course of successful treatment. This similar pattern of unfolding indicates some amount of overlap between the two constructs. Fuertes et al. also found that in less successful dyads, the real relationship and the working alliance followed different patterns of unfolding, with therapists' ratings of the working alliance decreasing in the second and third quarter of treatment followed by an increase in the last quarter of treatment, and therapists' rating of the real relationship decreasing over the course of treatment in less successful dyads. These findings indicate that although related, the working alliance and the real relationship, from the perspective of the therapist, seem to be distinct constructs. Lococo et al. (2011) studied 50 client therapist dyads and found that client-rated real

relationship not only predicted outcome but contributed significantly to the working alliance in predicting outcome. The finding lends support for the real relationship existing as a construct separate from the alliance. Marmarosh et al. (2008) found a significant relationship between client ratings of the real relationship after the third session and client perceptions of the working alliance ($r=.79$, $p<.001$) and therapists' perceptions of the working alliance ($r=.35$, $p<.01$). Positive correlations between therapist ratings of the working alliance and the real relationship have also been noted in Gelso et al. (2005; r = .47) and Fuertes et al. (2007; r =.50) studies. Results of these studies indicate that the positive relationship between working alliance and the real relationship is stronger for patient ratings (r around .79) as compared to therapist ratings. These high correlations in client ratings have led to the question of whether the real relationship and working alliance are different constructs as perceived by the clients. Gelso (2011) addresses these findings as likely to emerge as a result of the working alliance measure used in the studies. The Bond subscale of the working alliance measure contained items relating more to personal feelings than therapist-client collaboration, thereby accounting for some of the high correlations. Despite this however, it does seem that the working alliance and the real relationship relate more closely for clients as compared to therapists.

Transference and the Real Relationship. There are three studies that have examined the relationship between transference and the real relationship. Gelso et al. (2005) asked therapists to make ratings of the strength of their real relationship with the last client they had seen in the past week with whom they had conducted at least five psychotherapy sessions. Therapists also rated the strength of the transference these clients had exhibited. Results indicated that the strength of the real relationship related

negatively to negative transference. This result was replicated in Marmarosh et al.'s (2009) study. Marmarosh et al. used 31 therapist-patient dyads to correlate therapists' ratings of transference with therapists' and patients' ratings of the real relationship. Results revealed that therapists' ratings of the real relationship were negatively related to their ratings of negative transference ($r=-.50$, $p<.001$). Fuertes et al. (under review) studied six therapy dyads and found that in cases of successful treatment, the ratings of real relationship followed an increasing trend whereas transference ratings decreased over the course of treatment.

These studies support Gelso and Carter's (1994) claim that the presence of either transference or real relationship in the foreground will be associated with the other receding to the background. The negative association is revealed between the real relationship and negative transference, though not for positive transference. It is believed that measures of positive transference may share features inherent in the real relationship, and it thus becomes difficult to tease the two constructs apart. Furthermore, Gelso and Carter have also postulated that transference and the real relationship are not mutually exclusive components and can exist simultaneously. The correlations between real relationship and negative transference are low to moderate, corroborating Gelso and Carter's claim that there may be instances that involve the presence of both transference as well as the real relationship.

Countertransference and the Real Relationship. Although no published study to date has highlighted the relationship between countertransference and the real relationship, Palma and Gelso (2011) presented findings in this realm. The researchers examined supervisors' rating of trainees' countertransference behavior along with

supervisor and trainee-rated strength of the real relationship between the trainee and a client. Results indicated that trainees' real relationship was negatively associated to countertransference. Fuertes et al. (under review) also found that in cases where treatment was less effective, an increase in negative countertransference was accompanied by a decrease in the strength of the real relationship. It is hoped that the present study adds to our understanding of the relationship between countertransference and the real relationship.

Summarizing in the context of the present study

This review of literature highlights that despite recognition of the therapy relationship as a vital element in psychotherapy, there are aspects of it that have not been studied effectively. The tripartite model helps to understand the therapy relationship in terms of components that have roots in psychodynamic thought, and are now being recognized, through a growing body of research, in all forms of therapy. The findings of the present study add to the literature in the following ways; 1) expanding our knowledge of the existence of the components in heterogeneous forms of therapy, 2) understanding how each of these components contributes to session outcome, and lastly 3) testing to see if the components relate to each other in theoretically predicted ways. In the next chapter, these questions will be addressed in detail. Hypotheses are posited, based on previous empirical findings and/or theoretical reasoning.

Chapter 3 - Statement of Problem

There has been a plethora of research on the therapeutic relationship and its components over several decades. A tripartite model of the therapeutic relationship developed by Gelso and his collaborators (Gelso & Carter, 1985, 1994; Gelso & Hayes, 1998; Gelso and Samstag, 2008) elaborates on the following components of the therapeutic relationship: a working alliance, a transference-countertransference configuration, and a real relationship. Although studies have examined the components of therapeutic relationship and their relation to session outcome, there is no study to date that has looked at all the components of the tripartite model together. In the present study therapists' ratings of the working alliance, transference, countertransference and the real relationship as they relate to each other and session outcome were examined. Insight as rated by the therapist will be studied as a moderator in the relationship between transference and session outcome. Lastly, the underlying factor structure of the measures of the therapy relationship used in the study will be examined through an exploratory factor analysis.

It is hoped that the present study will add to the psychotherapy literature by dissecting some of the relational dynamics taking place in the session. Gelso and Carter (1994) postulated propositions regarding how the components are likely to relate to each other. The present study aims to test empirically a few of the propositions offered by Gelso and Carter. In a study by Johansson et al. (2010), insight was found to be a key agent in the process of change in dynamic therapy. These investigators discovered that insight mediated the relationship between transference interpretation and session outcome. Another replicated finding is that transference and insight interact to predict

treatment outcome and session quality (Gelso, Hill & Kivlighan, 1991; Gelso et al, 1997). In order to explore further these findings, the interaction of insight and transference were examined in terms of how it relates to session outcome. The following hypotheses and research questions are posited based on previous research and theoretical rationale, which are presented immediately after each hypothesis or hypothesis cluster and question.

Hypotheses:

Hypothesis 1: Therapist-rated working alliance and transference will relate to each other such that,

Hypothesis 1.a. Therapist-rated working alliance will correlate negatively with overall therapist-rated transference.

Hypothesis 1.b. Therapist-rated working alliance will correlate negatively with therapist-rated negative transference.

Gelso and Carter (1994) theorized that the working alliance and transference influence one another. They conceptualized that positive transference tended to strengthen the alliance at times, whereas negative transference tended to weaken it. Gelso and Carter also stated that the working alliance influences transference by allowing for increased client awareness and manifestation of transference-based feelings. Through this rationale it was hypothesized that the working alliance and transference (especially negative) will relate to each other negatively. Patton, Kivlighan and Multon (1997) have found some support for this hypothesis. The results of their study indicated that the working alliance appeared to influence transference, though transference did not similarly influence the alliance.

The present study posited hypotheses on the relationship between working alliance and overall transference as well as the working alliance and negative

transference. No hypothesis was made on positive transference, as it was expected to be hard to tease out from the working alliance. Furthermore, the relationship between positive transference and the working alliance tends to be complicated in terms of how they may relate to each other positively or negatively. For example an eroticized positive transference may end up impeding the working alliance (Gelso and Carter, 1994). Keeping in mind these reasons, I had chosen not to offer a hypothesis about the relationship between positive transference and the working alliance in the present study.

Hypothesis 2: Therapist-rated working alliance and real relationship will relate to each other such that therapist-rated working alliance will correlate positively to the therapist-rated strength of the real relationship.

The working alliance refers to the working bond that exists between the client and the therapist. It has been theorized that the working alliance stems from the real relationship, which is the human bond present in all relationships. Research has largely supported a positive relationship between the working alliance and the real relationship (Gelso et al., 2005; Marmarosh et al., 2009; Fuertes et al., 2007). Furthermore empirical research has indicated that the two constructs are empirically distinguishable from each other.

Hypothesis 3: Therapist-rated transference and real relationship will relate to each other such that,

> *Hypothesis 3.a. Overall therapist-rated transference will correlate negatively with the therapist ratings of the strength of the real relationship*
>
> *Hypothesis 3.b. Therapist-rated negative transference will correlate negatively with the therapist ratings of the strength of the real relationship.*

Transference contains an element of distortion and the real relationship contains elements of genuineness and realism. It makes sense to test whether the two will relate to each other negatively. Research has indicated a negative relationship between negative transference and the real relationship (Fuertes et al., under review; Marmarosh et al., 2009; Gelso et al., 2005). On the other hand previous studies have not found any relationship between positive transference and the real relationship. Gelso et al. have pointed out that though positive transference relates to variables similarly to negative transference, the correlations associated with positive transference are relatively lower. In line with these findings, positive transference had been excluded from the hypotheses.

Hypothesis 4: Therapist-rated countertransference and real relationship will relate to each other such that,

> *Hypothesis 4.a. Overall therapist- rated countertransference will correlate negatively with the therapist ratings of the strength of the real relationship*
>
> *Hypothesis 4.b. Therapist-rated negative countertransference will correlate negatively with the therapist ratings of the strength of the real relationship.*

There has been no published study to date examining the relationship between the real relationship and countertransference. However, Palma and Gelso (2011) presented findings that highlighted a negative correlation between supervisor ratings of therapists' countertransference to a given patient and therapist and supervisor-rated real relationship with the same patient. Fuertes et al. (under review) have also found that in less successful cases, an increase in negative countertransference is accompanied by a decline in the real relationship. Furthermore, previous empirical research has indicated a negative relationship between therapists' countertransference and the working alliance (Ligiero &

Gelso, 2002). Ligiero and Gelso also found a negative relationship between negative countertransference and the working alliance. Bordin (1979, 1994) conceptualized the working alliance as comprising of a working bond. In understanding the real relationship as the 'human bond', we can expect countertransference to relate to the real relationship in ways similar to the working alliance.

It is relevant to mention here that countertransference in the present study was assessed based on therapist ratings. Even though countertransference assessment largely utilizes supervisor/ rater evaluations, I believe that self-reported countertransference holds merit as well. Along with being relatively easy to use, therapists are likely to be able to pick up on and report their own behaviors during the session, especially when these behaviors seem less fitting to the situation. Furthermore, it is important to note that it is the therapists who have the most experience with the client, and their assessment may yield information of which raters and supervisors may not be aware.

Hypothesis 5: Therapist-rated countertransference and working alliance will relate to each other such that,

Hypothesis 5.a. Overall therapist-rated countertransference will correlate negatively with the therapist ratings of the working alliance.

Hypothesis 5.b. Therapist-rated negative countertransference will correlate negatively with the therapist ratings of the working alliance.

Empirical research has indicated a negative relationship between therapists' countertransference and the working alliance (Ligiero & Gelso, 2002; Rosenberger & Hayes, 2002). Ligiero and Gelso also found a negative relationship between negative countertransference and the working alliance. Following these results, I hypothesized a

negative relationship between therapist rated countertransference and the working alliance, and a negative relationship between negative countertransference and the working alliance.

Hypothesis 6: Session outcome will relate to the components of the therapeutic relationship such that

Hypothesis 6.a. Working alliance ratings will correlate positively with session outcome

Hypothesis 6.b Real relationship ratings will correlate positively with session outcome

Hypothesis 6.c. Countertransference ratings will correlate negatively with session outcome

Gelso et al. (2005) found a positive relationship between the real relationship and session outcome, thereby indicating that the stronger and more positive the real relationship, the better the session outcome. In a similar way, the working alliance is expected to relate to stronger, positive session outcome. Studies have corroborated the positive relationship between the working alliance and both session outcome and treatment outcome in psychotherapy (e.g. Horvath et al., 2011; Horvath & Bedi, 2002; Pesale, 2011). A number of studies have found a positive relationship between the real relationship and treatment/session outcome (e.g. Ain & Gelso, 2011; Gelso et al., 2005; Marmarosh et al., 2008; Fuertes et al., 2007). There is a body of literature that has found a negative relationship between countertransference and both, session outcome and treatment outcome (e.g. Hill, Nutt-Williams, Heaton, Thompson, & Rhodes, 1996;

Ronsenberger & Hayes, 2002; Hayes, Riker and Ingrim, 1997; Hayes, Gelso, & Hummel, 2011). The aforementioned hypotheses were proposed in line with these studies.

Hypothesis 7: Therapist perceptions of client insight will moderate the relationship between the transference and session quality such that for high ratings of client insight, negative transference will be positively correlated with session quality, whereas for low ratings of client insight, negative transference will be negatively related to session quality.

Gelso and Carter (1994) theorized that the effect of transference on treatment outcome will not emerge as a main effect, rather the effect of transference will depend on the insight possessed by the client. Thus, transference will have a positive effect on treatment when there is greater client insight and a negative effect on treatment when client insight is poor. Two studies support this proposition (Gelso et al, 1997; Gelso et al, 1991). In both studies a significant negative transference X insight interaction was found in relation to treatment/session outcome. Thus, in both studies it was found that high negative transference-high insight was associated with a more positive outcome, whereas a high negative transference-low insight was associated with a more negative outcome in counseling. In the present study this interaction was examined in terms of how it relates to session outcome.

Research Questions

Research Question 1: How does each component of the tripartite model uniquely contribute to session outcome?

Each component's unique contribution to session outcome was examined by using simultaneous regression analysis. There has been no study to date examining this

research question, and thus I had chosen not to put forth any hypotheses relating to this question. At this point, there is no indication of which of the therapy components contribute to session outcome more than the others. Analysis of data will shed some light on how each component contributes to session outcome, while holding the other components constant. Furthermore, this will allow for a more in-depth scrutiny of how the therapy relationship components predict session outcome.

Research Question 2: What is the factor structure underlying the items from the measures of the therapy relationship used in the present study?

The components of the therapy relationship studied in the present study have been talked about over decades of psychotherapy research. However, they emerge from theory and have not been studied empirically in terms of how they all exist together. This research question was conceived in order to statistically examine the way in which items from the measures of the four components of the therapy relationship group together. It was reasoned that this would allow for interpretation of findings from an exploratory factor analysis in terms of how they fit with the tripartite model of the therapy relationship. Furthermore, examining the underlying factor structure would also contribute to the knowledge on the interrelations between components as hypothesized by previous researchers (e.g. Gelso & Samstag, 2008; Gelso & Carter, 1994). Results were expected to provide a more nuanced understanding of the parts of the components that overlap or associate with one another.

Chapter 4 - Method

Design

The current study employed a descriptive field study design. The study obtained measures of the following variables from therapists: working alliance, transference, client insight, countertransference behavior, the real relationship, and session outcome.

Participants

Participants in the study were 249 licensed psychotherapists in the United States. Participants were recruited based on their membership in the Division of Independent Practice and the Division of Psychotherapy of the American Psychological Association. Two hundred and eighty participants began the online survey, and 249 therapists completed the survey to some extent. Thirty-one participants did not fill in any measure after the demographic questionnaire and thus they were excluded from the present sample.

Participants completed a demographic questionnaire that provided the following information. Almost half the participants in the present study were male (N=114, 45.8 %). A majority of the sample indicated their ethnic/racial background to be Caucasian/White (91.6%, N=228), eight therapists indicated their ethnic/racial background as African American/Black (3.2%), six as Asian/ Pacific Islander (2.4%), three as Hispanic/Latino (1.2 %) and six participants indicated their ethnic/racial background as “other” (1.6%). Nearly 80 percent of the therapists stated their highest educational degree to be a doctorate, 14 therapists had a Masters degree and 15 therapists had a Bachelors degree. Therapists were asked to indicate the extent to which a specific theoretical approach was representative of their work in psychotherapy on a five-point scale (5=strongly representative, 1=not at all). Results revealed the following mean-

ratings for each of the theoretical approaches: humanistic/experiential = 3.35 (SD= 1.21), psychodynamic/psychoanalytic= 3.35 (SD=1.40), cognitive/behavioral= 3.87 (SD=1.14), Systems=3.06 (SD=1.26). Thirty-three therapists added to this list of theoretical approaches and indicated their theoretical orientation as also including an integrative framework, solution-focused framework, trauma work, mindfulness/spirituality, gestalt theory and biopsychosocial framework. These mean ratings highlight that the current sample was highly diverse in terms of the theoretical orientation. The sample also comprised of experienced therapists, as indicated by a high average number of years of experience (average=27.34; SD= 9.74). Lastly therapists were asked to indicate the session number for which they completed the measures of the study. A number of therapists did not state a specific session number, and commented that they had seen the client for over ten or hundreds or thousands of sessions. In such cases, the average was calculated by entering the minimum number of sessions (e.g. ten for a therapist who mentioned he/she had seen the client for more than ten sessions), and thus the average is an underestimate of the actual value. Furthermore, some therapists did not indicate a session number or left a comment that made it impossible to approximate the number of sessions, and thus were excluded from the analysis of mean number of sessions. The average number of sessions was found to be 79 (SD=234.94), indicating that the majority of the sample comprised of therapists seeing their clients for long-term therapy.

Measures

Working Alliance Inventory–Short Form (WAI-S). Therapists rated their working alliance with their client using the WAI-S. The full-length version of the WAI developed by Horvath and Greenberg (1986, 1989) comprises of 36 items. Based on

Brodin's (1979) theory, the measure has three subscales assessing client-therapist agreement on goals, agreement on tasks and bond. Items are rated on a 7-point scale where 1(never) and 7(always). The measure has been studied through the years and is found to be highly reliable (Kivlighan and Shaughnessy, 2000) and valid. It has been found to relate to treatment outcomes, client characteristics and therapist technical activity (Constantino, Castonguay & Schut, 2002; Kivlighan and Shaughnessy, 2000). The present study used the Therapist-version of the short form of the WAI, proposed by Tracey and Kokotovic (1989). The short form comprises of 12 items. The authors selected 4 items with the highest factor loadings from each subscale. Validity evidence was indicated by the WAI-S having a similar factor structure to WAI. The WAI-S was found to be reliable, with alpha coefficients for clients and therapist subscales and total score ranging from .83 to .98. The WAI-S has been used in a number of studies indicating that, similar to the full-scale WAI, WAI-S relates to client termination from therapy (Samstag, Batchelder, Muran, Safran, & Winston, 1998; Tryon & Kane, 1995), treatment adherence (Corris et al., 1999) and therapy outcome ratings (Kivlighan & Shaughnessy, 1995; Weerasekera, Linder, Greenberg, & Watson, 2001). Busseri and Tyler (2003) have provided further support for the interchangeability of the WAI and the WAI-S. Both subscale and total scores from both the WAI and WAI-S were similar in terms of descriptive statistics. Internal consistency coefficients for therapist ratings of the final session on the WAI-S short form ranged from .86 to .96. In the present study, the internal consistency alpha was found to be .90 for the WAI-S.

Therapy Session Checklist-Transference Items (TSC–TI). Therapists rated client transference using the three single item measure of transference from the Therapist

Session Checklist (Graff and Luborsky, 1977). The terms transference, positive transference and negative transference are defined in a paragraph. Transference is defined as client material that was a) overtly or covertly related to the therapist and b) a manifestation of or displacement from an early important relationship (though the previous person need not be mentioned). Positive transference is defined as positive reactions to or perceptions of the therapist that were transference based. Negative transference refers to negative reactions to or perceptions of the therapist that were based on transference. Therapists rated the amount of transference, negative transference and positive transference for their most recent session using a 5-point scale (1=none or slight, 2=somewhat, 3=moderate, 4=much and 5=very much).

Therapists rated the amount of transference, negative transference and positive transference for their most recent session using a 5-point scale (1=*none or slight* and 5=*very much*). Luborsky and colleagues (Graff & Luborsky, 1977; Luborsky, Crabtree, Curtis, Ruff, & Mintz, 1975; Luborsky, Graff, Pulver, & Curtis, 1973) have found a moderate level of interrater reliability for these singe-item measures of transference between therapists and external raters. Gelso et al. (1997) calculated alpha coefficients for the transference items for the first four sessions in their sample to assess the stability of the measure and found them to be .66 for positive transference, .86 for negative transference, and .69 for the amount of transference. A very high degree of stability was not expected as transference was presumed to vary among sessions (Gelso et al., 1997). In terms of construct validity, the TSC-TI ratings are found to relate to a range of phenomena in theoretically predicted ways. For example, Graff and Luborsky (1977) found the single item transference ratings to be theoretically consistent for successful and

unsuccessful analysis; Gelso et al. (1991) found transference ratings using the TSC-TI to relate to counselor intentions in ways expected by theory; Multon, Patton and Kivlighan (1996) found the TSC-TI to relate to a multi-item measure of transference in predicted ways.

Insight. Therapists-rated client insight using items developed by Gelso et al. (1991). Similar to the transference measure, therapists were given a definition of insight. Insight was defined as, "The extent to which the client displays accurate understanding of material being explored. Understanding may be of the relationship, client's functioning outside of counseling, or aspects of the client's dynamics and behavior. Intellectual insight reflects an under- standing of cause– effect relationships but lacks depth because it does not connect to affect underlying the client's thoughts. Emotional insight connects affect and intellect; the client is thus connected emotionally to his or her understanding." Therapist's rated emotional insight, intellectual insight and overall insight on a 5-point scale where 1 = *none or slight* and 5 = *very much*.

Although it is recognized that single item measures can be problematic, their usefulness lies in their practical nature (Gelso et al., 2005). Furthermore, there is empirical evidence that supports using the aforementioned single item measures for transference and insight. The transference items are found to relate to a multi item measure of transference (Multon et al., 1996). Additionally the single-item measure of transference has satisfactory validity and reliability evidenced through a number of studies. Lastly, the interaction between transference and insight as they predict session quality and treatment outcome has been studied using these measures (Gelso et al., 1991; Gelso et al., 1997).

Inventory of Countertransference Behavior (ICB; Friedman & Gelso, 2000). The ICB consists of 21 items. Observers rate therapist countertransference behavior on a 5-point scale, where 1=to little or no extent and 5=to a great extent. Thus, a higher score indicates greater countertransference behavior being displayed in the session. The ICB gives scores on positive countertransference, negative countertransference as well as overall countertransference. Examples of the items include "The therapist rejected the client in the session," and "The therapist talked too much during the session." The measure is found to have sound internal consistency, indicated by an alpha coefficient of .79 (Friedman & Gelso, 2000). Countertransference behavior, as assessed by the ICB, was found to relate negatively in theoretically predicted ways to countertransference management, providing support for convergent validity of the measure (Friedman & Gelso, 2000). Furthermore it related positively to a single-item measure of countertransference behavior (The CT index) in a session.

Ligiero and Gelso (2002) used the ICB and reported an alpha coefficient of .79 for each scale. Similar to Friedman and Gelso (2000), they found significant correlations between the Negative Countertransference subscale and the CT Index ($r=.70$, $p<.001$) and the Positive Countertransference subscale and the CT Index ($r=.34$, $p<.01$). Furthermore, Ligiero and Gelso found that the countertransference behavior as assessed by the ICB related to the working alliance in theoretically predicted ways, providing evidence for the validity of the measure.

The present study used therapists' ratings of their own countertransference behavior. Items containing 'The therapist' in the measure were changed to 'I/me' derivatives. Although problems with therapist ratings of countertransference are

recognized, there is some support for self-reported countertransference behavior. Hayes, Riker & Ingrim (1997) found a positive correlation between counselors' and supervisors' scores on the single item CT index ($r = .62$, $p < .01$). In another line of evidence, Betan, Heim, Clonkin, & Westen (2005) developed a self-report countertransference measure and found significant correlations between countertransference factors (e.g. overwhelmed/disorganized, helpless/inadequate, special/overinvolved) and personality disorder symptoms indicating that countertransference responses occur and are reported by clinicians of different theoretical orientations in coherent and predictable patterns. Lastly, in a qualitative study (Hayes et al., 1998) countertransference was identified in 80% (101 of 127) of the sessions that therapists conducted. Though qualitative, this data indicates the possibility of therapists' being able to identify their countertransference. These findings provide some evidence for self-reported countertransference behavior. Keeping in mind the practical nature and feasibility of therapist ratings, they were used in the present study. In the present study, the internal consistency alpha was .73 for the positive countertransference behavior subscale, .86 for the negative countertransference behavior subscale, and .89 for the total measure.

Real Relationship Inventory Therapist Form (RRI-T; Gelso et al. 2005). The RRI-T (Gelso et al, 2005) contains 24 items. The total score is an indicator of the strength of the real relationship. The inventory contains two subscales of 12 items each, Realism and Genuineness. The therapists rated items pertaining to themselves, the client and their relationship. The ratings were made on a 5-point scale (1=strongly disagree, 5=strongly agree). The Realism and Genuineness subscales have items pertaining to magnitude of the real relationship and valence of the real relationship. Higher scores indicate stronger

real relationship in terms of realism and genuineness. The coefficient alpha values have been found to be .79 for the Realism subscale, .83 for the Genuineness subscale and .89 for the total scale (Gelso et al, 2005). Construct validity for the measure is seen in associations between scores on the RRI-T and other measures of the therapy components in theoretically predicted ways. For example, the RRI-T is found to relate positively to working alliance (Gelso et al, 2005; r =.47; Fuertes et al 2007; r =50). Results of Marmarosh et al (2009) revealed that therapists' ratings of the real relationship were negatively related to their ratings of negative transference (r=-.50, p<.001). A number of studies (Gelso et al, 2005; Marmarosh et al, 2009; Fuertes et al, 2007) have found positive correlations between session/treatment outcome and therapist rating of the real relationship using the RRI-T. In the present study, the internal consistency alpha was found to be .89 for the measure.

Session outcome. In the present study session outcome is evaluated in terms of three aspects of a therapy session; session evaluation, session depth and session quality. Items from three measures were used to assess session outcome.

Session Evaluation Scale (SES; Hill & Kellems, 2002). The SES is a subscale of the Helping Skills Measure developed by Hill & Kellems (2002). It consists of four items to be rated on a 5-point scale, where 1=strongly disagree and 5=strongly agree. The SES was originally developed to assess clients' evaluation of the session. The measure was found to have sound reliability (alpha = .89). Validity evidence was indicated by the SES correlating in expected ways with client ratings of session impact, including session depth, understanding, problem solving, and quality of the client–counselor relationship.

Lent et al. (2006) used counselor ratings of session evaluation using the SES. Using the same 5-point scale counselors rated the modified SES items, e.g. "I did not feel satisfied with what my client got out of this session"; "I thought this session was helpful for my client". The Lent et al. study found counselor ratings of the SES to yield adequate internal consistency reliability estimates (alpha coefficients ranging from .86 to .87 depending on the session number). In the present study, the internal consistency alpha of the SES was found to be .75.

Session Evaluation Questionnaire – Depth subscale (SEQ- Depth; Stiles & Snow, 1984). The SEQ contains 24 bipolar adjective pairs that assess session depth, smoothness, positivity and arousal. The Depth subscale was used in the present study. Each item was rated by a therapist on a 7-point semantic differential scale. Higher scores are indicative of greater depth of the session, in terms of therapists' perceptions of the sessions as being deep, powerful, valuable, full and special. Stiles & Snow (1984) reported therapist rating on the Depth subscale to be reliable (alpha =. 91). The depth subscale has been widely used in literature and its validity has been supported in terms of the theoretically predicted relations of Session Depth to a number of counseling process and outcome measures (Stiles et al., 1990). The Depth subscale was found to relate in expected ways to the components of the therapy relationship (Gelso et al. 2005). Gelso and his colleagues reported the coefficient alpha for the Depth subscale to be .82. In the present study the coefficient alpha for this scale was found to be .82.

Session Quality. In addition to the scales mentioned above, session outcome was also evaluated on therapists' ratings of the overall quality of the session using a single item. Therapist's rated the overall quality of the sessions on a five-point scale, where

1=very poor, and 5=very good. It is hoped that this item adds to the scales above in assessing the overall nature of the session. Gelso et al. (1991) successfully used this single item of session quality to assess the interaction of transference and insight in predicting session quality.

Procedure

Recruiting participants. Participants were recruited based on their membership in the Division of Psychotherapy (Division 29) and Division of Independent Practice (Division 42) of the American Psychological Association. The membership lists of division 29 and division 42 were obtained from APA.org and state licensed members were shortlisted to find members who are practicing psychotherapy. From this list, every third member of the divisions was contacted. In cases of invalid email and members that overlapped between the two divisions, the next member on the list was contacted.

A total of 1670 potential participants were contacted via email (562 from Division of Psychotherapy and 1108 from the Division of Independent practice, see Appendix F). The first email was a personalized invitation for participating in the study and included a brief description of the study, the eligibility criteria, and a link to an online survey. The potential participants were informed that the study is being conducted in order to examine aspects of the therapeutic relationship. In the letter, the therapy relationship was emphasized on as an important aspect of psychotherapy and participation was requested in efforts to broaden our understanding of certain aspects of the therapy relationship. Potential participants were told that the survey would take around 20 minutes of their time and that their help would be greatly appreciated. Participants were promised a summary of the findings and notification of any publications that would results form the

study. The eligibility criteria specified that in order to participate in the study, the therapist needed to be working with a client they have had at least 5 sessions with and who was over the age of eighteen. Those who respond affirmatively to these two questions were then requested to follow the link that directed them to an online survey. Participants were asked to read a consent form and give consent via an online signature before proceeding to the measures section. Therapists were instructed to fill in the measures for the last client they had seen for at least five sessions.

In cases where therapists did not respond to emails, reminder emails were sent (See Appendices G & H). A total of three reminders were sent following the initial email (reminder 1 *n*=1414; reminder 2 *n* =1222; reminder 3 *n* =1145). Each reminder email was sent after seven to ten days of not receiving a response following the previous email.

Of the 1670 potential participants contacted, 277 were ineligible to participate in the present study or had email addresses that were listed incorrectly. Therapists indicated a number of reasons that deemed them ineligible to participate, such as working with minors, exclusive assessment practice, retirement, no longer practicing psychotherapy and so on. Of the remaining 1393 participants, 119 declined to participate stating that they were not interested in participating, unable to participate or had no time to participate at present. 249 therapists participated in the study, resulting in a return rate of 17.88 percent.

Analysis

The relationships among the components were examined by conducting bivariate correlational analyses. Furthermore, the relationships between the therapeutic components (working alliance, transference, countertransference and the real

relationship) and session outcome were examined on the basis of the intercorrelations between them. Along with correlational analysis, hierarchical regression was used to examine the role of insight as a moderator in the relationship between transference and insight. A simultaneous regression analysis was used to determine how each component of the therapy relationship contributes uniquely to session outcome. Lastly, an exploratory factor analysis was conducted in order to study the underlying factor structure of the components of the therapy relationship measured in the present study.

Chapter 5 - Results

In the present study, the components of the tripartite model of the therapy relationship, namely the therapist-rated working alliance, real relationship, transference and countertransference, were examined. The results of the study will be presented in the context of hypotheses and research questions posited in three domains: (a) The interrelations among the components, (b) the relationship between the components and session outcome and (c) the components underlying the therapy relationship components measured in this study as indicated by a principal components analysis.

Descriptive Data

Descriptive data including means, standard deviations, skewness, kurtosis and reliability estimates for the items of each measure are presented in Table 1. All measures demonstrated adequate reliability.

Tests for normality (kurtosis and skewness statistics) indicated that scores on ICB and negative transference were positively skewed. This violated the assumption of normality required for the correlation and regression analyses. Thus data were transformed using log transformation. Natural logs of the values of the variable (ICB and negative transference) were used, rather than original raw values, for all the correlation and regression analyses utilizing ICB and negative transference scales. Log transformations reduce skewness of data and are recommended for positively skewed data. Here, although the log transformations reduced skewness of data, scores on the total ICB scale as well as the negative ICB subscale continued to be positively skewed. It was decided to continue with the analyses despite the skewness of data based on the rationale that this skewness pattern exists naturally in the population. Previous

Table 1

Descriptive data for therapist ratings on the Working Alliance Inventory, the Real Relationship Inventory, Transference items, Inventory of Countertransference Behavior, Session Evaluation Scale, Session Evaluation Questionnaire-Depth Subscale and Session Quality

	N	Item Range	Mean Item Score	SD	Skewness	Kurtosis	Cronbach's alpha
WAI	246	1-7	5.71	0.65	(0.69)	0.95	0.90
RRI	248	1-5	3.81	0.45	(0.18)	0.29	0.89
Transference Amount	248	1-5	2.40	1.02	0.40	(0.41)	
Transference Positive	248	1-5	2.87	1.16	(0.03)	(1.05)	
Transference Negative	246	1-5	1.40	0.67	1.90	4.32	
Transference Neg_transform	246	1-5	0.11	0.17	1.15	0.06	
ICB_total	245	1-5	1.32	0.35	5.25	47.93	0.89
ICB_positive	245	1-5	1.47	0.43	2.57	15.66	0.73
ICB_negative	245	1-5	1.18	0.33	7.10	73.02	0.86
ICB_total_transform	245	1-5	0.11	0.09	1.78	7.95	
ICB_neg_transform	245	1-5	0.15	0.11	0.72	1.26	
ICB_pos_transform	245	1-5	0.06	0.08	3.01	16.55	
SES	247	1-5	4.27	0.49	(0.28)	(0.32)	0.75

SEQ-Depth	246	1-7	4.99	1.01	(0.53)	0.56	0.82

Note: WAI=Therapist ratings of the Working Alliance Inventory-Short form; RRI=Therapist ratings of the Real Relationship Inventory; Transference Neg_transform= log transformation of therapist ratings of negative transference; ICB_total=Therapist ratings on the Inventory of Countertransference Behavior; ICB_positive = Therapist ratings on the positive subscale of Inventory of Countertransference Behavior; ICB_negative = Therapist ratings on the negative subscale of Inventory of Countertransference Behavior; ICB_total_transform = log transformations of therapist ratings on the Inventory of Countertransference Behavior; ICB_neg_transform = log transformations of therapist ratings on the negative subscale of the Inventory of Countertransference Behavior; ICB_pos_transform = log transformations of therapist ratings on the positive subscale of the Inventory of Countertransference Behavior; SES = Therapist ratings on the Session Evaluation Scale; SEQ-Depth= Therapist ratings on the Depth subscale of the Session Evaluation Questionnaire.

studies on countertransference (Friedman & Gelso, 2002; Mohr et al., 2005) have found a similar pattern and dealt with the skewness by using log transformations.

Three measures were used to assess session outcome, the Session Evaluation Scale (SES; Hill & Kellems, 2002), The Session Evaluation Questionnaire-Depth subscale (SEQ-D; Stiles & Snow, 1984) and a single item for session quality. The scales were correlated significantly with one another (r's in the .7 range, see Appendix K), and thus z-scores for each of the scales were computed and combined to yield a single score for session outcome.

Results of the analyses are presented in the following section. Due to the large number of variables in the study, attempts to control Type I error were made by setting the alpha level at .01 rather than the conventional .05 level.

Interrelations Among the Therapy Components.

The correlation matrix with the Pearson correlation coefficients for the interrelations of the components is presented in Table 2.

Hypothesis 1: Therapist-rated working alliance and transference will relate to each other such that, therapist-rated working alliance will correlate negatively with overall therapist-rated transference and therapist-rated negative transference.

Results partially supported this hypothesis in that therapist-rated negative transference was found to significantly and negatively correlate with the working alliance ($r=-.25$; $p<.01$) whereas overall amount of transference did not correlate significantly with the working alliance at the established alpha level ($r=-.12$; $p>.01, <.05$). Although there was no hypothesis posited about the relationship between working alliance and positive transference, results

Table 2

Correlation matrix for Session outcome, Working Alliance Inventory, Real Relationship Inventory, Inventory of Countertransference Behavior, Transference items

	1	2	3	4	5	6	7	8
1.Session Outcome	____							
2.WAI	.50***	____						
3.RRI	.42***	.63***	____					
4.ICB_total	-.18***	-.30***	-.10	____				
5.ICB_neg	-.24***	-.32***	-.13*	.83***	____			
6.Trans_total	-.06	-.12*	.01	.11	.14*	____		
7.Trans_neg	-.13*	-.25***	-.20***	.11	.13*	.37***	____	
8.Trans_pos	-.01	.00	.14*	.08	.08	.73***	.17***	_____

Note: Session outcome= Session Evaluation Scale + Session Evaluation Questionnaire-Depth subscale. WAI=Therapist ratings of the Working Alliance Inventory-Short form; RRI=Therapist ratings of the Real Relationship Inventory; ICB_total = log transformations of therapist ratings of the Inventory of Countertransference Behavior; ICB_negative = log transformations of therapist ratings of the negative subscale of the Inventory of Countertransference Behavior; Trans_total= Theapist ratings of amount of transference; Trans_neg = = log transformation of therapist ratings of negative transference

**p<.05. **p<.01. ***p<.001*

of a two-tailed Pearson correlation indicated that positive transference as measured in the present study does not correlate with the working alliance (r=.00; p>.05).

Hypothesis 2: Therapist-rated working alliance and real relationship will relate to each other such that therapist-rated working alliance will correlate positively with the therapist-rated strength of the real relationship.

The results of the present study supported this hypothesis. The Pearson's correlation coefficient between therapist ratings of the working alliance and the real relationship was found to be statistically significant (r=.63 ; p<.01).

Hypothesis 3: Therapist-rated transference and real relationship will relate to each other such that, overall therapist-rated transference and therapist-rated negative transference will correlate negatively with the therapist ratings of the strength of the real relationship.

Similar to Hypothesis 1, results partially supported this hypothesis in that negative transference was found to significantly correlate negatively with the real relationship (r = -.20; p<.01), whereas overall amount of transference did not correlate significantly with the real relationship. Even though the relationship between positive transference and the real relationship was not hypothesized, results indicated a positive relationship between two (r=.14), although it did not attain the .01 level of significance (p<.05).

Hypothesis 4: Therapist-rated countertransference and real relationship will relate to each other such that, overall therapist- rated countertransference and therapist-rated negative countertransference will correlate negatively with the therapist ratings of the strength of the real relationship.

Results from the data of the present study did not support this hypothesis. Therapist-rated negative countertransference did not correlate significantly with the real

relationship at the .01 level (r=-.14; p<.05), and therapist-rated overall countertransference did not relate to the real relationship (r=-.10 ; p>.05)

Hypothesis 5: Therapist-rated countertransference and working alliance will relate to each other such that, overall therapist-rated countertransference and therapist-rated negative counter transference will correlate negatively with the therapist ratings of the working alliance.

Results offered support for this hypothesis. Overall therapist-rated countertransference negatively correlated with the working alliance (r=-.30; p<.01) and therapist-rated negative countertransference negatively correlated with the working alliance (r=-.32; p<.01).

Therapy Components and Session outcome

Hypotheses were posited on how each of the components was expected to relate to session outcome. The correlation matrix with the Pearson correlation coefficients for each of the components and session outcome are presented in Table 2. Each hypothesis is presented following a description of the analyses and results.

Hypothesis 6: Session outcome will relate to the components of the therapeutic relationship such that

Hypothesis 6.a. Working alliance ratings will correlate positively with session outcome

Hypothesis 6.b Real relationship ratings will correlate positively with session outcome

Hypothesis 6.c. Countertransference ratings will correlate negatively with session outcome

The hypotheses were tested using Pearson's correlation coefficients. The correlation matrix is presented in Table 2. Results indicated support for all three hypotheses. Therapist-rated working alliance related positively to therapist-rated session outcome (r=.50; p<.01), the therapist ratings of the real relationship related positively to therapist-rated session outcome (r=.42; p<.01), and countertransference as rated by the therapist related negatively to therapist-rated session outcome (r=-.18; p<.01)

Hypothesis 7: Therapist perceptions of client insight will moderate the relationship between the transference and session outcome such that for high ratings of client insight, negative transference will be positively correlated with session outcome, whereas for low ratings of client insight, negative transference will be negatively related to session outcome.

A hierarchical regression analysis was conducted to test the moderating effect of emotional insight on the relationship between negative transference and session outcome. Negative transference scores were entered in the first step, emotional insight scores were added in the second step, and the interaction term scores were added in the last step. Scores were centered around the mean to prevent multicollinearity. The results of the regression model are presented in Table 3. Results of Step 1 indicated the first model (including just negative transference) explained 1.6% of the variance in the model (Adj. R^2=.16, p<.05). Step 2 indicated that the second model (emotional insight and negative transference) significantly predicted session outcome over and beyond Model 1 (R^2 change= .26, Fchange (235) =86.22, p<.01). The overall model of the two predictor set (emotional insight and negative transference) was also found to be significant (F(2, 235)=46.34, P<.01). Step 3 highlighted that Model III (negative transference, emotional

insight and their interaction) significantly predicted session outcome overall (F (3,234)= 31.28, p<.01). However, it did not add any incremental value to Model II (R^2 change= .00, Fchange (234) =1.14, p>.01), thus indicating that the moderation hypothesis was not supported by the current data.

Further analyses were conducted with individual measures of session outcome to determine if the regression model looked different for different measures of session outcome. Results of the hierarchical regression model with SEQ-Depth as the dependent variable and negative transference, emotional insight, and the interaction term entered at different steps as mentioned above, are presented in Table 4. Results indicated that Model 1(negative transference) did not significantly predict session depth (Adj R^2=.00, F (241)=1.33, p>.05). Model II (negative transference and emotional insight) significantly predicted session depth (F (2,240)=24.46, p< .01), and added incremental value to Model1 (R^2 change= .164, Fchange (240) =47.37, p<.01). Model III (negative transference, emotional insight and interaction) significantly predicts session depth (F(3,239)=18.18, p<.01), however the prediction of Model III over and beyond Model II is significant only at the .05 level (R^2 change= .016, Fchange (239) =4.80, p<.05). The results of the hierarchical regression analysis revealed that the interaction term in the third step was significant at the .05 level. The interaction plot is presented in figure 1.

The plot indicates that the association between negative transference and session depth depends on insight levels, such that at high insight level, negative transference is positively related to session depth, whereas at low insight levels, negative transference is negatively related to session depth. Although the interaction was not found to be

Table 3

Hierarchical regression analyses for Negative Transference, Emotional Insight and Session Outcome

Step and variable	Total R^2	Adj. R^2	R^2 change	F	F change	df
Step 1						
NT	0.02*	0.02*	-	4.747*	-	236.00
Step 2						
EI	0.28**	0.28**	0.26***	46.33***	86.22***	235.00
Step 3						
NT*EI	0.29	0.28	0.00	31.28***	1.14	234.00

*Note: Dependent variable= Session outcome; NT= Negative transference; EI= Emotional Intelligence; Sig.=Significance level. *p<.05. **p<.01. ***p<.001*

Table 4

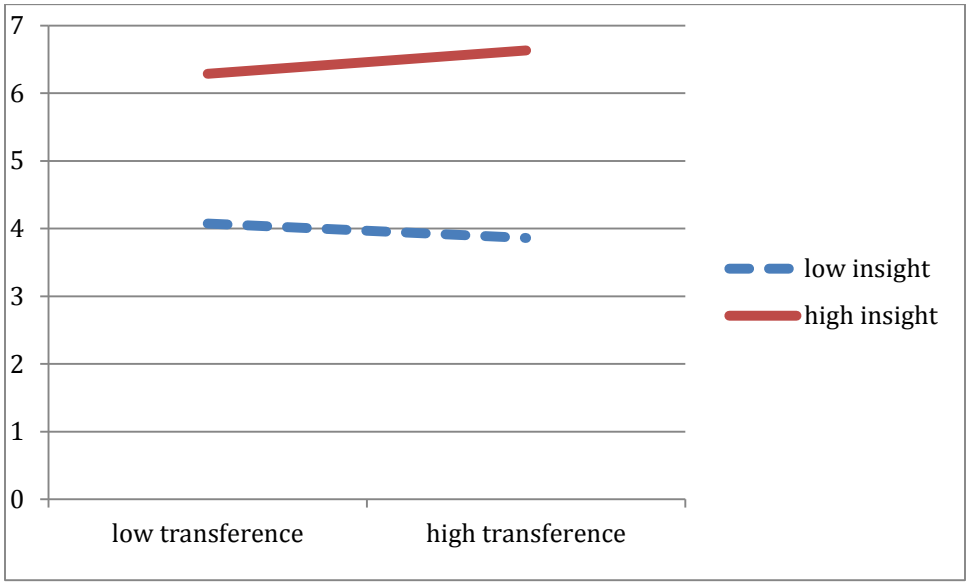
Hierarchical regression analyses for Negative Transference, Emotional Insight and Session Depth

Step and variable	Total R^2	Adj. R^2	R^2change	F	F change	df
Step 1						
NT	0.01	0.00	-	1.33	-	241.00
Step 2						
EI	0.17***	0.16***	0.16***	24.46***	47.37***	240.00
Step 3						
NT*EI	0.19*	0.18*	0.02*	18.18***	4.80*	239.00

*Note: Dependent variable= Session Evaluation Questionnaire- Depth subscale; NT= Negative transference; EI= Emotional Intelligence. *p<.05. **p<.01. ***p<.001*

Figure 1

Interaction between Negative Transference, Emotional Insight and Session Depth



SEQ-Depth scores on y-axis

significant at the established alpha level, the interaction was plotted in order to understand the nature of the moderation effect. It is recognized that there may be certain factors that have prevented the interaction replicated in previous studies to emerge in the current study, and these reasons will be highlighted in the discussion chapter. Neither the regression model using SES nor the model using the single-item measure of session outcome as the dependent variables is presented here, as the results of this model were essentially identical to the model using a linear combination of all three measures of session outcome presented above.

Research Question 1: How does each component of the tripartite model uniquely contribute to session outcome?

A simultaneous regression was conducted to examine how each component of the tripartite model contributes to session outcome. Scores on the working alliance, the real relationship, countertransference behavior and negative transference were entered into the regression model, with session outcome as the dependent variables. Results of the simultaneous regression model are presented in Table 5. Results indicated that the four components predict 26.9 percent of the variance (Adjusted R^2=.27, F (231)=22.738, p<.01). Further examination of the regression model revealed that the real relationship and working alliance as rated by the therapist significantly predicted session outcome after adjusting for all components of the tripartite model (RRI: B=.69, p<.01; WAI: B=1.01, p<.01). In other words the real relationship and working alliance as rated by the therapist uniquely contribute to session outcome, and negative transference and countertransference as rated by the therapist do not contribute to session outcome, when other components of the tripartite model are controlled.

Table 5

Simultaneous regression model for the components of the therapy relationship and session outcome

Model	B	Std. Error	Beta	t	Significance level
Constant	-8.265	1.013		-8.157	.000
RRI	.686	.272	.183	2.525	.012
WAI	1.009	.199	.393	5.080	.000
Neg_Transference	.114	.593	.011	.192	.848
ICB_total	-.348	1.270	-.016	-.274	.784

Note: RRI= The Real Relationship Inventory; WAI = The Working Alliance Inventory; Neg_Transference= Negative transference; ICB_total = Inventory of Countertransference Behavior

Exploratory Factor Analysis

Research question: *What is the factor structure underlying the items from the measures of the therapy relationship used in the present study?*

This research question was posited to examine how the items from various components of the therapy relationship measured in the current study group together. The aim here was to assess how this underlying factor structure would make sense in the context of the tripartite model of the therapy relationship. There has been no study to date examining the underlying structure of the tripartite model or of these therapy components.

An exploratory factor analysis with principal components analysis (PCA) was used to explain the data in this study. PCA was chosen over a principal-axis factoring method (PAF) because it allows for an analysis of all the variance among variables. In other words, it focuses not just on the common variance among variables but also the variance unique to each variable (Kahn, 2006), thus allowing for examination of both the common and unique variance between the components of the tripartite model.

The first step in the EFA was to test the factorability of the data. The Bartlett's test of sphericity and Kaiser-Meyer-Okin (KMO) test were used for this purpose. The KMO was found to be .807 and the Bartlett's test was significant χ^2 (1770) = 6460.65, $p < .01$ indicating that factor analysis would be appropriate with this data set.

In the current study, 60 items were factor analyzed. Oblique rotation was used as the factors were expected to correlate with each other, according to both theory and previous research (e.g. Gelso & Carter, 1994; Gelso & Hayes, 1998; Gelso & Samstag, 2008). Two criteria were used to determine the number of factors to extract, the scree plot and

parallel analysis. The scree plot (see Appendix J) was examined for the point where the curve "elbows" to estimate the number of factors to extract (Cattell, 1966). The scree plot indicated that a four or five factor solution would appropriately describe the data. Parallel analysis was also conducted as a more objective method of determining the number of components to be extracted (Horn, 1965). In parallel analysis, the eigenvalues (EV) from data prior to rotation (raw data) and data from a random matrix with identical dimensionality to the research data are compared (Franklin et al, 1995). According to parallel analysis, components with EV greater in the raw data as compared to the data in the random matrix are significant and are to be retained. Results (presented in Appendix I) indicated that the first four factors could be extracted from the data. Here, the Eigen values associated with the first four components are significant as the raw data values are greater than the percentile values associated with the random matrix.

Following results from the scree plot and parallel analysis, a four-factor solution was deemed to be the most appropriate to describe the data. An oblique rotation (or directoblimin) was used on the four-factor model, and the pattern loadings from the analysis are presented in the following tables. Most researchers use the pattern matrix to interpret findings as pointed out by Field (2005). Graham (2003) has pointed out the importance of the structural matrix as well, and has suggested looking at both of the matrices. In the present study, the pattern matrix and structural matrix yielded similar results and thus only the pattern matrix loadings are presented in the following table

Table 6

Pattern matrix of Factors using Oblique Rotation

			Factors			
	Scale	Items	1	2	3	4
1	WAI-Task	_____ believes the way we are working with her/his problem is correct.	**0.84**	0.06	-0.08	-0.05
2	WAI-Goals	We have established a good understanding between us of the kind of changes that would be good for _____	**0.81**	0.03	0.05	-0.01
3	WAI-Task	_____ and I both feel confident about the usefulness of our current activity in therapy.	**0.77**	0.08	0.10	0.06
4	WAI-Task	_____ and I agree about the steps to be taken to improve his/her situation.	**0.70**	0.00	0.08	-0.07
5	WAI-Goals	We are working towards mutually agreed upon goals	**0.69**	-0.38	-0.07	0.01
6	WAI-Goals	I have doubts about what we are trying to accomplish in therapy.	**0.63**	0.02	-0.09	-0.11
7	WAI-Bond	_____ and I have built a mutual trust.	**0.62**	0.01	0.23	-0.02
8	WAI--Goals	_____ and I have different ideas on what his/her real problems are.	**0.61**	0.05	0.11	-0.27
9	WAI--Bond	I am confident in my ability to help _____.	**0.61**	-0.31	0.06	0.04
10	WAI-Task	We agree on what is important for _____ to work on.	**0.60**	-0.37	0.04	-0.14
11	RRI-G	My client shares with me the most vulnerable parts of him/herself	**0.52**	0.07	0.17	0.13
12	RRI-G	My client holds back significant parts on	**0.39**	0.07	0.12	-0.23

		him/herself.				
13	WAI-Bond	I appreciate _____ as a person.	**0.32**	-0.04	0.25	0.02
14	ICB	I behaved as if I were absent during the session.	0.15	**0.87**	-0.03	-0.02
15	ICB	I spent time complaining during the session.	0.14	**0.81**	-0.04	-0.10
16	ICB	I inappropriately apologized to the client during the session.	0.20	**0.79**	-0.04	0.11
17	ICB	I treated the client in a punitive manner in the session.	0.13	**0.76**	-0.04	0.04
18	ICB	I inappropriately questioned the client's motives during the session.	0.10	**0.75**	-0.01	-0.02
19	ICB	I acted in a dependent manner during the session	0.21	**0.71**	-0.15	-0.12
20	ICB	I acted in a submissive way with the client during the session	-0.06	**0.70**	0.00	0.12
21	ICB	I behaved as if I were "somewhere else" during the session.	0.09	**0.70**	-0.08	0.04
22	ICB	I distanced myself from the client in the session.	0.03	**0.59**	-0.13	0.22
23	ICB	I seemed to agree too often with the client during the session.	-0.18	**0.57**	0.21	0.00
24	ICB	I rejected the client in the session.	0.01	**0.57**	-0.14	-0.02
25	ICB	I was critical of the client during the session.	-0.07	**0.55**	-0.04	0.03
26	ICB	I frequently changed the topic during the session.	-0.04	**0.54**	0.04	0.04
27	ICB	I inappropriately took on an advising tone with the client during the session.	-0.19	**0.53**	0.09	0.12
28	ICB	I provided too much structure in the session.	-0.13	**0.53**	0.10	-0.07
29	ICB	I engaged in too much self-disclosure during the session.	-0.13	**0.53**	0.16	-0.09
30	ICB	I was apathetic toward the client in the session.	0.08	**0.46**	-0.06	-0.02

31	ICB	I talked too much in the session.	-0.10	**0.39**	0.01	0.03
32	ICB	I oversupported the client in the session	-0.21	**0.39**	0.05	0.01
33	ICB	I Colluded with the client in the session.	-0.19	**0.30**	0.01	-0.19
34	RRI-R	My client feels liking for the "real me."	-0.05	-0.07	**0.76**	-0.01
35	RRI-G	We feel a deep and genuine caring for one another.	-0.04	0.09	**0.69**	0.23
36	RRI-R	My client's feelings toward me seem to fit who I am as a person.	0.02	-0.17	**0.68**	-0.14
37	RRI-R	I feel there is a "real" relationship between us aside from the professional relationship.	-0.13	-0.01	**0.66**	0.10
38	RRI-R	My client is able to see me as a real person separate from my role as a therapist.	-0.11	-0.13	**0.66**	-0.19
39	RRI-R	My client has little caring for who I "truly am."	0.09	0.07	**0.65**	0.13
40	RRI-R	My client has respect for me as a person.	0.03	-0.19	**0.61**	0.09
41	RRI-R	My client and I have difficulty accepting each other as we really are.	0.17	-0.15	**0.59**	-0.16
42	RRI-R	The relationship between my client and me is strengthened by our understanding of one another.	0.03	-0.01	**0.58**	0.16
43	RRI-G	I value the honesty of our relationship.	0.23	0.05	**0.57**	-0.03
44	RRI-G	My client and I are able to be genuine in our relationship.	0.22	0.06	**0.56**	-0.09
45	RRI-G	My client genuinely expresses his/her positive feelings toward me.	0.27	0.11	**0.50**	0.25
46	RRI-G	My client and I are honest in our relationship.	**0.34**	0.12	**0.45**	0.00
47	RRI-G	My client genuinely expresses a connection to me.	**0.34**	0.09	**0.44**	**0.39**
48	WAI-	I believe	**0.33**	0.02	**0.42**	0.04

	Bond	_____ likes me.				
49	RRI-R	I do not like my client as a person.	0.16	0.01	**0.39**	-0.16
50	RRI-G	There is no genuinely positive connection between us.	-0.01	0.00	**0.35**	-0.04
51	RRI-G	It is difficult for me to express what I truly feel about my client.	0.26	0.02	**0.32**	-0.17
52	RRI-G	I hold back significant parts of myself.	0.14	0.14	**0.31**	-0.30
53	RRI-R	I am able to realistically respond to my client.	0.27	-0.01	**0.30**	-0.10
54	ICB	I befriended the client in the session.	-0.25	0.27	**0.30**	-0.21
55	RRI-G	I have difficulty being honest with my client.	0.27	-0.01	**0.30**	-0.16
56	Trans	Amount of transference	-0.05	0.02	0.20	**0.72**
57	Trans	Positive transference	0.02	-0.02	0.29	**0.68**
58	RRI-R	My client has unrealistic perceptions of me.	0.08	-0.12	0.24	-0.56
59	Trans	Negative transference	-0.14	0.00	-0.05	**0.50**
60	RRI-R	My client distorts the therapy relationship.	0.21	-0.18	0.27	-0.48

Results of the EFA indicate support for the tripartite model. Four distinct factors emerged that resembled working alliance, real relationship, transference and countertransference. Although transference, and countertransference remained distinct factors, there was some overlap in the constructs of working alliance and real relationship. The four factors are described in the following section.

Factor 1: The Working Alliance. There were nine items that had factor loadings greater than .60 on this factor. Four of these items were from the Task subscale of the Working Alliance Inventory- Short form. They included aspects of the alliance such as believing the work being done is correct, the usefulness of therapeutic work and agreement on the steps needed for improvement. Three items of the Goal subscale of the Working Alliance Inventory loaded highly on this factor, including aspects such as agreement on changes that will be good for the client, mutual goals between the therapist and client, and fewer doubts about therapeutic work. Two items of the Working Alliance Inventory- Bond subscale, mutual trust between the therapist and the client and therapist's belief in his/her ability to help the client, loaded highly on this factor. The items with smaller loadings (ranging from .30- .60) were also examined to help expand the understanding of this factor. Interestingly, four items from the Real Relationship Inventory- Genuineness subscale also loaded on this factor. These four items tapped into the client sharing or holding back significant aspects of himself/herself, client and therapist being honest in their relationship and the client expressing a genuine connection to the therapist. Lastly two more items from the Working Alliance Inventory- Bond subscale, client liking the therapist and the therapist appreciating the client as a person, loaded on this factor (loadings lying close to .30).

Factor 2: Countertransference Behavior. Twenty items loaded distinctly on the second factor. All of these items were from the Inventory of Countertransference Behavior. This factor seems to be defined by the extent to which therapists' engage in behaviors that seem excessive or inappropriate in the session. Interestingly, the items that loaded highly on this factor (factor loadings greater than .60) included both negative as well as positive countertransference behaviors. Examples from the negative countertransference behavior subscale included items such as "I spent time complaining in the session", "I treated the client in a punitive manner in the session", "I inappropriately questioned the client's motives in the session". Examples of positive countertransference subscale items that loaded highly are, "I inappropriately apologized to the client in the session", "I acted in a dependent manner during the session", "I acted in a submissive way with the client during the session".

Factor 3: The Real Relationship. Twenty-two items had factor loadings greater than .30 on this factor. Seven items had factor loadings greater than .60 on this factor, of which six were from the Real Relationship Inventory - Realism subscale (RRI-R), and one was from the Real Relationship Inventory- Genuineness subscale (RRI-G). Items that loaded highly included therapist's views on how the client perceived the therapist, or therapist's views on their relationship. For example, therapist's perceptions on the extent to which the client liked him/her, perceived him/her without distortions, and cared and respected the person of the therapist. Other items that loaded on this factor (factor loadings ranging from .30- .60) included items from both the real relationship subscales, RRI-R and RRI-G. Predictably, a Bond subscale item from the Working Alliance

Inventory-S, “I believe my client likes me”, loaded on factor 3 as well as factor 1. Another unexpected item that loaded on factor 3 (albeit with a small factor loading of .30) was an item from Inventory of Countertransference Behavior- positive subscale, “I befriended the client in session.”

Factor 4: Transference. The last factor in the analysis comprised of the three single-items measuring transference, with loadings greater than .50. Amount of transference, positive transference and negative transference were included in this factor. Lastly, an item from RRI-G “My client genuinely expresses a connection to me”, was also found to load on this factor (loading = .39).

Chapter 6 – Discussion

The components of the tripartite model of the therapy relationship were studied in terms of their relationship with session outcome and the interrelations among the components. Furthermore, an exploratory factor analysis was conducted to study the underlying factor structure of the measures of the four components of therapy relationship used in the study. In the following sections the findings of the study will be discussed. Each component of the tripartite model will be elaborated upon, first in terms of its relation to session outcome and its interrelation with the other components. This discussion will be followed by an examination of the results of the factor analysis, in terms of how they fit with the tripartite model of the therapy relationship. Following explanation of the results, implications and limitations of the study will be discussed.

The Working Alliance

Results of the present study revealed a positive correlation between therapist-rated working alliance and therapist-rated session outcome ($r=.50$, $p<.01$). This finding is consistent with previous literature. Recently Horvath et al. (2011) conducted meta-analyses examining the relationship between the working alliance and treatment outcome. Results of the meta-analyses revealed a robust relationship between outcome and working alliance in individual therapy, the working alliance accounting for approximately 7.5 percent of the variance in treatment outcome. Other major reviews, too, have indicated a relationship of similar effect size between treatment outcome and working alliance (Horvath & Bedi, 2002; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000).

The working alliance, in the present study, was conceptualized as comprising of three aspects; agreement on treatment goals, consensus on therapeutic tasks, and a bond between the therapist and the client (Bordin, 1975). The correlation found in the present study lends support to a large effect size relationship between the working alliance and session outcome. Moreover, it highlights that this relationship exists across theoretical orientations of individual therapy since the sample consisted of therapists with varying theoretical orientations. The number of sessions of individual therapy ranged from five to 1500, thus highlighting that the working alliance and session outcome relationship exists for not just all forms of therapy, but also for a very wide range of sessions. In sum, it seems that when therapists' perceive a strong bond and an agreement on tasks and goals with their client, they are likely to also perceive greater session depth, session quality and session effectiveness.

Results also revealed that along with the real relationship, the working alliance significantly predicts session outcome in a model where negative transference, countertransference behaviors, the real relationship and the working alliance as perceived by the therapist, are looked at together. Results suggest that therapists perceive the working alliance as a key element in predicting session outcome, and its presence along with the real relationship negates the potential effects of negative transference and countertransference behaviors in session. In order to make sense of this finding, it is essential to understand the interrelations between the working alliance and other components of the tripartite model.

The working alliance and the real relationship. The results of the study supported the hypothesis in that the working alliance and the real relationship were found

to relate positively to each other ($r=.63$; $p < .01$). This finding replicates those from previous studies that have found therapist ratings of the real relationship and therapist ratings of the working alliance to be correlated with one another to a moderate extent (Marmarosh et al., 2009; Fuertes et al., 2007; Gelso et al., 2005). In a recent study Fuertes et al. (under review) found that the real relationship and the working alliance followed a similar pattern of unfolding in brief treatment, thereby indicating an overlap between the two constructs. In the present study, a simultaneous regression examining all the components of the therapy relationship together revealed that both the working alliance and the real relationship relate independently to session outcome. The moderate to strong relationship between the real relationship and the working alliance, as well as their unique contribution to session outcome, suggests both a substantial relationship between the two, as well as differentiation, in that they exist as two distinct variables (Gelso, 2011).

Keeping in mind that this study was correlational rather than experimental, and that cause-and-effect interpretations are not possible on the basis of the methodology, it is interesting to think of the positive correlation between the working alliance and the real relationship in terms of theoretical suggestions. Greenson (1967) and Gelso (2011) have theorized that the working alliance emerges from the real relationship. Another possibility could be that a strong working alliance allows for a therapist to perceive more genuine and realistic feelings in the therapy relationship. The moderate to strong correlation between the real relationship and working alliance indicates that therapists of differing theoretical orientations see the two as similar but also can identify the real relationship and the working alliance as distinct constructs. Gelso (2011) points out that

the working alliance pertains to the *work* of therapy, in terms of tasks, goals and the working bond, whereas the real relationship entails a more personal connection involving a genuine, reality-based, and authentic person bond. Thus, even though both the real relationship and the working alliance concern themselves with the relationship between client and therapist, and because these overlap considerably, one focuses on the personal relationship and the other on the working relationship of therapy.

The working alliance and the transference configuration. In the present study, as theorized, therapists' perceptions of the working alliance were found to relate negatively to therapists' perceptions of the negative transference ($r=-.25$; $p< .01$). There was a relatively smaller and statistically nonsignificant association between therapist-rated working alliance and therapist-rated overall amount of transference ($r= -.12$; $p<.05$). No association was found between positive transference and the working alliance ($r=.00$; $p>.05$)

Although the association between the working alliance and transference has not been studied extensively, the present finding is in line with a few studies that have examined this relationship. For example, Marmarosh et al. (2008) found a negative relationship between therapist ratings of the working alliance and negative transference ($r=-.44$; $p< .01$). A reason for this interrelation between working alliance and transference can be understood in the context of Patton et al.'s (1997) study. The authors used a short-term psychoanalytic counseling model to study individual therapy over the course of two semesters and found that the working alliance seemed to influence transference although transference did not influence the alliance. Gelso and Carter (1994) have suggested a two-way model with both transference and the working alliance influencing one another.

The negative relationship between the working alliance and negative transference can also be explained through the rupture-repair alliance theory (Gelso & Hayes, 1998; Safran & Muran, 2000), which states that an initial strong alliance can weaken in the presence of ruptures instigated by negative transference. Although further research is needed to gain clarity on the influences taking place between the working alliance and negative transference, it makes sense at this point to understand their relationship in terms of how they both tend to relate to one another. It is clear that there is a moderately negative relationship between the two constructs as perceived by therapists.

An additional note on positive transference seems in order at this point. No association was seen between therapist-rated positive transference and the working alliance. Therapist ratings on positive transference have not related to constructs as expected in previous studies (e.g. Marmarosh et al., 2008; Gelso et al., 2005). In the case of the working alliance, a possible theoretical reason for a lack of significant relationship with positive transference could be that the relationship between the two can be both positively and negatively valenced. For example, in the eyes of therapists, positive transference may share components with the working alliance and be positively connected to the working alliance. Imagine an idealizing transference that allows for a stronger working alliance between the therapist and client. However, it can also work in the opposite manner, for example, an eroticized transference can end up impeding the working alliance (Greenson, 1967; Gelso & Carter, 1994).

In terms of countertransference, results of the present study indicated a negative relationship between therapist-rated countertransference and therapist-rated working alliance ($r=-.32$; $p<.01$). This supported the hypothesis put forth and replicates previous

findings in this realm. Ligiero and Gelso (2002) found a negative relationship between negative countertransference and working alliance as rated by both supervisors and therapists. Ligiero and Gelso pointed out that a reason for this negative relationship between working alliance and countertransference behavior may be that negative countertransference behaviors prevent the formation of a strong working alliance. An alternative explanation could be that a weak working alliance, indicative of a lack of agreement on tasks and goals, and a poor working bond, might call forth negative countertransference behaviors on the part of the therapist. A negative relationship was also found between the working alliance and positive countertransference as rated by the therapist ($r=-.24$; $p<.01$). This finding was surprising, as previous studies have not found an association between positive countertransference behaviors and the working alliance. Ligiero and Gelso used therapists in training, and their supervisor ratings in their study. It may be that in the present sample, licensed therapists are better able to pick up on their positive countertransference behaviors as distinct from the working alliance. Positive countertransference behaviors involve being excessively agreeable and friendly with the client, and it is possible that therapists were able to identify their own tendencies to engage in these behaviors. It seems as though for the sample in the present study, excessive positive behaviors on the part of the therapist are associated with difficulty in the agreement of tasks, goals and the working bond of therapy.

Thus, the results of the present study indicate a negative relationship between the working alliance and negative transference, and the working alliance and countertransference behaviors. Further research can help determine the direction of this

association, in terms of how the working alliance and transference configuration influence one another.

Summarizing the working alliance. In conclusion, the results highlight a positive association between the working alliance and session outcome, and the working alliance and the real relationship. Negative associations were seen between the working alliance and the transference configuration. Furthermore, results from a simultaneous regression revealed that the working alliance uniquely contributed to session outcome when other components of the tripartite model were controlled. In light of the above discussion, the following theoretical explanations for this finding can be posited. It may be that the working alliance comprises of different elements in terms of how it relates to session outcome. An element of working alliance uniquely contributes to session outcome. Thus, the presence of a strong working alliance itself is enough, to some extent, in predicting an effective and deep session in the eyes of the therapist. However, we can also conjecture that there may also be different aspects of the working alliance that predict session outcome by associating with other components of the tripartite model. For example, consider the aspect of the working alliance that relates negatively to negative transference. A possibility is that the working alliance may play the role of a mediator as negative transference weakens the working alliance and reduces session effectiveness. On the other hand, a strong working alliance, may lead to a resolution of negative transference, increasing session effectiveness. Similarly, another aspect of working alliance may predict session outcome by mediating the relationship between countertransference behaviors and session outcome. The presence of strong countertransference behaviors may weaken the working alliance in the session leading to

poor session outcomes, or alternatively a strong working alliance may prevent the manifestation of countertransference behaviors leading to better session outcomes. It is important to note here that these are possible theoretical explanations, and further research is needed to delineate the causal direction among these relationships. The message here is that the working alliance, at least as perceived by therapists, contributes to session outcome uniquely, and possibly also through its relationship with other therapy components.

The Real Relationship

In the present study, as hypothesized, a positive relationship was found between therapist ratings of the real relationship and therapist-ratings of session outcome ($r = .42$; $p < .01$). There have been conflicting findings in the realm of therapist ratings of the real relationship and session/treatment outcome. A number of studies have found a positive association between therapist ratings of the real relationship and treatment outcome/ session outcome (Mamarosh et al., 2009; Fuertes et al., 2007; Gelso et al., 2005; Ain & Gelso, 2011; Eugster & Wampold, 1996). The result of the present study is consistent with the those of Gelso et al. (2005), where a significant association was seen between therapist ratings of the real relationship and session depth ($r = .36$, $p < .01$). However two studies (LoCoco et al., 2011; Gelso et al., 2012) did not find a significant relationship between therapist ratings of the real relationship and treatment outcome. Gelso et al. (2012) have pointed out that these differing results may be due to differing outcome measures, client and therapist samples and stage of treatment. More research is needed in this realm to tease out these differences. Despite conflicting findings, it is clear that there is some evidence of a relationship between the real relationship and session outcome.

First, Gelso's (2011) review indicates that in all studies, either the client's, the therapist's, or both client and therapist perceptions of the real relation are related to indices of outcome (session or treatment). Second, Gelso et al. (2012) point out that converging ratings of the real relationship by the therapist and client are associated with better outcomes. In other words, a strengthening real relationship, both in the eyes of the client and therapist, is associated with positive outcomes.

Gelso (2011) has talked about two aspects of the real relationship, genuineness and realism. Genuineness refers to the extent to which a person can be authentic with the other, and realism refers to the extent to which a person can see the other in ways that befit him/her. The current study highlights, then, that in the present sample, when therapists perceive their relationship with their clients as being authentic and realistic, they tend to recognize greater session depth, quality and effectiveness, for different forms of therapy and for a wide range of sessions.

Along with correlational data, the real relationship-session outcome association is also seen in the results of a simultaneous regression examining the role of all components of the tripartite model together in predicting session outcome. As mentioned previously, results indicated that the real relationship and working alliance, as perceived by the therapist, uniquely predict session outcome. The aspects of the real relationship that predict session outcome may be independent as well as inter-related with other therapy components. A more detailed understanding of this phenomenon can be reached through an examination of the inter-relationship between the real relationship and the transference configuration.

The real relationship and the transference configuration. Perhaps because of their interrelation, the working alliance and the real relationship related to the transference configuration in a somewhat similar manner. Therapist ratings of the real relationship were found to relate negatively to therapist ratings of negative transference, consistent with previous studies (Marmarosh et al., 2008; Gelso et al., 2005). The negative correlation in the present study ($r=-.20$; $p< .01$) supports the claim that the presence of either transference or real relationship in the foreground will be associated with the other receding to the background (Gelso & Samstag, 2008; Gelso & Carter, 1994). The modest correlation also highlights that although negatively correlated, the real relationship and negative transference are not the opposite of one another. At this point the direction of causality between the real relationship and negative transference is not clear. It may be that the real relationship and negative transference are both influencing one another, or specifically one is influencing the other. It may help to understand the nature of these influences in terms of stages of therapy. For example, a strong negative transference, especially in the early stages of therapeutic work, may prevent the development of a strong personal bond between the therapist and the client. However, it may also be that a strong personal bond creates an environment that prevents negative feelings from emerging in the session at a later stage in therapy. The nature of influence may also depend on whether therapy is successful or unsuccessful. Fuertes et al. (under review) found that in more successful dyads, the real relationship strengthens and transference declines. This pattern of declining transference in successful cases is similar to that found by Gelso et al. (1997). Fuertes et al. point out the possibility that a decreasing transference can represent resolution of transference, which in turn yields a

stronger real relationship. It could also be that a strong real relationship causes diminishing transference in more successful cases.

Similar to other findings in this study, and previous findings in this realm, positive transference did not relate to the real relationship as perceived by the therapist. It may be that positive feelings relating to transference are harder to identify and distinguish from other constructs. Markin and Kivlighan (1997) have pointed out that therapists tend to confuse positive transference with other aspects of the therapy relationship, and thus the interrelation between positive transference and the other components does not emerge significantly when therapist-ratings are used.

In terms of countertransference behaviors, analysis of the relationship between countertransference behaviors and the real relationship as perceived by therapists yielded mixed findings. As hypothesized, a negative relationship was found between negative countertransference behaviors and the real relationship ($r=-.13$, $p<.014$). However, contrary to the hypotheses, no significant relationship was seen between overall countertransference behaviors and the real relationship. Nor was there a relationship of the real relationship and positive countertransference behaviors. A reason for this mixed finding may rest on the fact that therapists rated their own countertransference behaviors. Therapist may be able to pick up on negative countertransference behaviors that relate to the real relationship, however, they may have had difficulty in picking up on other aspects of countertransference behaviors, such as positive behaviors, that relate to the real relationship. Palma and Gelso (2012) found somewhat similar results in that supervisors' ratings of the trainees' negative countertransference behaviors were found to relate negatively to the real relationship between the trainee and the client, whereas positive

countertransference behaviors were found to be unrelated to the real relationship. The authors reasoned that supervisors might be more tuned to negative countertransference behaviors in the session than positive countertransference behaviors in the session. Negative countertransference behaviors can be viewed as punitive in nature, whereas positive countertransference behaviors may be regarded as the therapist being supportive in the session. The same rationale can be applied for therapists rating their own countertransference behaviors as well.

Thus, the results suggest that from the therapist's perspective, negative countertransference behaviors are associated with a poor real relationship. It may be that the presence of a strong real relationship prevents the expression of negative countertransference behaviors on the part of the therapist. Alternatively, a situation where a client evokes unresolved feelings in the therapist may create a debilitating environment for the formation of a strong personal relationship between the client and the therapist. Though more research is needed in this realm to reach a definitive conclusion, Fuertes et al. (under review) did find that in cases of less successful dyads, ratings of real relationship decreased whereas ratings of negative countertransference increased in the second quarter of treatment, offering support for the negative relationship between the two constructs.

Summarizing the real relationship. Results of the present study indicate a positive relationship between the real relationship and session outcome, a negative relationship between the real relationship and negative transference, and a negative relationship between the real relationship and negative countertransference, as rated by therapists. The real relationship was also found to relate to session outcome uniquely

when all the components of the tripartite model were examined together. Similar to the working alliance, this suggests that there may be two aspects of the real relationship at work in predicting session outcome. The first acts independently and stands alone in its contribution to session outcome. However, there may be another aspect, one that overlaps with negative transference and negative countertransference in predicting session outcome. A strong real relationship might act as a mediator in facilitating the working through of negative transference, thereby increasing session depth, effectiveness and quality. Similarly, therapists perceiving a strong personal bond with their client might tend to keep their negative countertransference behaviors in check, thereby predicting better session outcomes. Future research is needed for a better understanding of these explanations. At present the message seems to be that the real relationship predicts session outcome uniquely, and possibly through its interrelation with the other components of the tripartite model.

The Transference Configuration

Countertransference and session outcome. Results of the present study indicated a negative relationship of small effect size between negative countertransference behavior and session outcome ($r=-.24$; $p<.01$), a negative relationship of small effect size between overall countertransference behaviors and session outcome ($r=-.18$; $p<.01$) and a non-significant relationship between positive countertransference behaviors and session outcome ($r=-.10$; $p>.10$).

These findings about countertransference and session outcome fit with Hayes et al.'s (2011) meta-analyses looking at effects of countertransference on treatment outcome. The results of the meta-analyses revealed that the average weighted r of

countertransference with outcome was found to be -.16 with a 95% confidence interval of -.26 to .06. A number of other studies have shown similar findings (e.g. Hayes et al., 2007; Williams & Fauth, 2005).

In the present study therapists rated their own countertransference behaviors. Results imply that from the therapist's perspective, negative countertransference behaviors, such as avoiding or being punitive in the session, are associated with lower levels of session outcome. In terms of overall countertransference behaviors, there may be moderating effects at work in the relationship between general countertransference behaviors and session outcome accounting for the small effect size relationship found in the present study. For example, Hayes et al. (2011) found that the relationship between countertransference and negative outcome differed for distal outcomes and proximal outcomes, thus indicating that the nature of outcomes may be a potential moderator at work here. Countertransference management may also be moderating the relationship between countertransference behaviors and session outcome. In certain cases therapists' might be able to manage their countertransference such that it does not associate with session outcome (Hayes et al., 1997).

Positive countertransference was not found to relate to session outcome. It is possible that therapists' may face difficulty in identifying aspects of positive countertransference behaviors that relate to session outcome. Friedman and Gelso (2000) have talked about supervisors facing difficulty in identifying positive countertransference behaviors accurately. Positive countertransference behaviors tend to be seen as supportive rather than indicative of dependency and enmeshment with the client. In sum, in the present study, results indicate that therapists were able to identify some of their

countertransference behaviors over a wide range of sessions to some extent and their perceptions of countertransference behaviors were found to be associated with poorer session outcomes.

Transference and session outcome. Contrary to hypotheses posited, no interaction was seen in the relationship between negative transference and session outcome as moderated by emotional insight. Instead, results indicated a main effect of emotional insight predicting session outcome, and a small and nonsignificant correlation ($r=-.13$; $p<.05$) between negative transference and session outcome. A more nuanced analysis of results also revealed an interaction pattern between negative transference, emotional insight and session depth (rather than overall session outcome) at the .05 level of significance.

The findings of the present study conflict with two previous studies in this realm (Gelso et al., 1991; Gelso et al., 1997). Both studies found a significant interaction effect with emotional insight moderating the relationship between negative transference and session quality, and negative transference and treatment outcome, respectively. A closer examination of methodological differences in the studies can perhaps explain the differing results. Psychotherapists in the Gelso et al. (1991) study were asked to fill measures for a session with a neurotic client. The present study did not specify the nature of client psychopathology, and thus a possibility may be that at the session level the interaction pattern exists for particular client psychopathologies. For example, when working with an anxious client, therapists may focus more on working through the negative transference by helping clients gain emotional insight, thereby resulting in better session outcomes. The process may look different when working with a severely

depressed client. Here, the therapist may not actively engage in working through the negative transference in that particular session.

A second explanation may relate to the high average number of sessions with the client in the sample used in the present study. Gelso et al. (1997) examined the moderation model for briefer forms of therapy and treatment outcome. It is possible that the negative transference-emotional insight interaction predicts treatment outcome in briefer forms of therapy. Gelso et al. (1997) found that negative transference increased through the first three quarters of brief therapy and dipped in the last quarter with successful cases whereas continued to increase in the last quarter with unsuccessful cases. Perhaps in longer-term work negative transference follows a different pattern, in that it dissipates over time when different forms of psychopathology are examined together.

The regression analyses with negative transference and insight predicting session outcome also indicated that the negative transference and insight model significantly explained the variance in session outcome (R^2=.26, p<.01) without the interaction terms. In other words, low negative transference and high emotional insight additively predicts good session outcome for therapists in this sample. It may be that as clients gain insight into their transferences, their negative transference to the therapist declines, and session outcome gets better.

Interestingly an interaction pattern was seen with negative transference, insight and session depth. Although the interaction effect was small (significant at the .05 alpha level as opposed to the .01 level used in this study), it replicated previous findings in this realm. The association between negative transference and session depth was found to depend on insight level, such that at a high insight level, negative transference was

positively related to session depth, whereas at a low insight level, negative transference was negatively related to session depth. At this point, it is not clear what contributes to the presence or absence of this moderation model. As suggested previously, a number of factors may be at work here and further research is needed to shed some light on these findings.

Analysis of the total amount of transference and positive transference revealed that the two did not correlate significantly with session outcome. This finding is consistent with other findings (e.g. Gelso et al., 2005; Marmarosh et al., 2008). In sum, findings from the present study reveal that transference does not clearly relate to session outcome across a wide number of sessions. At this point it makes sense to conjecture the presence of other moderating variables that are present in the relationship between transference and session outcome. Fuertes et al. (under review) found a change in pattern of transference (for both positive and negative transference) as treatment progresses, depending on whether cases are less successful or more successful. It may be that the association between transference and session outcome is more specific and needs a micro-level analysis in terms of stage and effectiveness of treatment.

Summarizing the transference-configuration. Negative transference and countertransference behaviors as perceived by the therapists relate negatively to session outcome when looked at individually. However, this relationship disappears when all the components of tripartite model are examined together in their association with session outcome. Specifically for the present sample, therapist ratings of countertransference behavior and negative transference did not uniquely contribute to session outcome. As discussed in previous sections, a possible reason for this finding is that the parts of

transference and countertransference behaviors that predict session outcome are those that are associated with the working alliance and the real relationship. Thus their contribution to session outcome may be mediated or moderated by the working alliance and the real relationship. Along with the real relationship and the working alliance, the relationship of the transference configuration and session outcome may also be moderated by a number of other variables in the following ways. First, the present sample consists of a wide range of sessions. It may be that the role of transference and countertransference in predicting session outcome is dependent on the stage of treatment. Second, for the sample in the present study, both countertransference and transference ratings fell below average, indicating that levels of countertransference and transference were low for the sample. A more nuanced examination may reveal that when countertransference and transference ratings have greater variability, they are more likely to predict session outcome. Lastly, the study deals with therapists' perceptions of transference and countertransference behaviors. Other perspectives, such as those of clients, supervisors and observers may reveal an association between the constructs and session outcome. In summary, results at hand indicate that transference and countertransference do not predict session outcome independently in the presence of the working alliance and the real relationship. It seems plausible that the predictive properties of transference and countertransference behaviors need to be studied in terms of moderating and mediating variables.

Factor Analysis

An exploratory factor analysis was conducted to study the factor structure underlying the measures and examine how this structure fits in the context of the tripartite

model. The factor analysis revealed the presence of four distinct factors. These four factors strongly resembled those posited by the tripartite model, and thus are labeled the working alliance, countertransference behaviors, the real relationship and transference. These factors are discussed in the following section in terms of their main features and similarities to the components of the tripartite model.

Working Alliance. An examination of highly loaded items on this factor can help in making sense of its key features. These included items from the Task subscale, the Goal subscale and the Bond subscale of the Working Alliance Inventory-Short form. These high loadings tell us that the key features of this factor pertain to the three aspects of the alliance as posited by Bordin (1995), tasks, goals and the working bond of psychotherapy. Interestingly, four items from the Real Relationship Inventory-Genuineness subscale also loaded on this factor (factor loadings ranging from .30-.60). These items tapped into the client sharing or holding back significant aspects of himself/herself, client and therapist being honest in their relationship and the client expressing a genuine connection to the therapist.

The factor loadings reveal that for therapist ratings, one component of the therapy relationship includes the tasks and goals aspects of the working alliance. Along with these, there also seems to be another aspect at work, the working bond that is genuine in nature. The working bond aspect includes mutual trust and a liking between the therapist and the client, however, the genuineness component adds to this working bond in specifying features such as the client sharing vulnerable aspects of himself/herself, honesty in their relationship and a genuine connection between the two. It may be that a working bond emerges in therapeutic work as an expression of genuineness, and thus

therapists perceive the two together. For example, an appreciation for the client as a person may lead to the therapist perceiving the client as more honest in their work. Alternatively it may also be that a strong working bond allows the therapist to view the client as being genuine and honest in their work. In terms of the tripartite model, the task and goal aspects of the working alliance seem to be well-defined aspects of the therapy relationship identified by the therapist. However therapists' perceptions also include the working bond and aspects of genuineness in the relationship in fitting with the tasks and goals of therapy.

Countertransference Behavior. All of the items that loaded highly on this factor were from the Inventory of Countertransference Behavior. This factor seems to be defined by the extent to which therapists' engage in behaviors that seem excessive or inappropriate in the session. In sum, the factor loadings on the second factor indicate that therapists are able to identify countertransference behaviors as distinct from other components of the therapy relationship.

The Real Relationship. Items from the Realism subscale of the Real Relationship Inventory loaded highly on this factor. These included therapist's views on how the client perceived the therapist, or therapist's views on their relationship. Other items that loaded on this factor (factor loadings ranging from .30- .60) included items from the real relationship subscales of Realism (RRI-R) and Genuineness (RRI-G). Predictably, a Bond subscale item from the Working Alliance Inventory-S, "I believe my client likes me" loaded on this component. Gelso (2011) had talked of the bond element present in both the real relationship and the working alliance with an important distinction; the bond component of the working alliance referred to the *working* bond, whereas the bond

element in the real relationship was reflective of a more *personal* bond. The aforementioned item does not specify the nature of the bond and thus loads on both the components, resembling the working alliance and the real relationship. Another unexpected item that loaded on Factor 3 (albeit with a small factor loading of .30), was an item from Inventory of Countertransference Behavior- positive subscale, "I befriended the client in session." It may be that unlike other countertransference behaviors that seem inappropriate and excessive, for many therapists befriending a client in session signifies sharing a personal bond with the client, thereby fitting with Factor 3 as opposed to Factor 2.

In conclusion, the third factor contains mostly items from the real relationship inventory and strongly resembles the real relationship as conceptualized by the tripartite model. The results of the present study indicate that therapists' perceive a distinct component of the therapy relationship as including a personal bond with the client, characterized by both genuine and authentic elements.

Transference. The last factor in the analysis comprised of the three single-items measuring transference, along with an item from RRI-G. The item from the RRI taps into the extent to which the client expressed a genuine connection to the therapist. It is possible that this genuine connection aspect in the therapy relationship lies opposite to the distortion inherent in transference and thus loads on both Factor 3 as well as Factor 4. Amount of transference, positive transference and negative transference were included in this factor. This suggests that therapists perceived transference as conceptualized by the tripartite model as a distinct component of the therapy relationship.

In conclusion, an exploratory factor analysis revealed the presence of four factors that greatly resembled those posited by the tripartite model of the therapeutic relationship. Therapists' perceptions of transference and countertransference (Factor 2 and Factor 3) behavior emerged as two distinct and clear factors. There was some degree of overlap between Factor 1 and Factor 3 in that a portion of genuineness and a bond between the client and therapist was present in both the components. Despite the overlap the factors were named the working alliance and real relationship, as the two factors seemed to be defined chiefly by items from the WAI-S and the RRI respectively.

Limitations

The findings of the present study have to be interpreted in light of its limitations. A key limitation of the study is its utilization of only therapist ratings. Ratings from a single source can be associated with a number of issues. First, using therapist ratings to examine therapy process and outcome variables can be challenged in terms of the importance of the therapist perspective in contributing to treatment effectiveness. However, although the importance of examining various perspectives in psychotherapy research is recognized, a growing body of literature provides support for using therapists' ratings to understand process and outcome variables in psychotherapy. Recently, Kim et al. (2006) found that approximately eight percent of the variance in outcome was accounted for by therapists, making a clear case for the importance of utilizing therapist perspectives in psychotherapy research. A second issue with the utilization of therapists' ratings is that therapists' self-reports on a number of variables can cause inflations in correlations between these variables. Effects are found to be most trustworthy when utilizing different rating sources (Gelso et al., 2012) and thus future research looking at

multiple sources may help in dealing with this limitation. A third issue lies in the possible bias in therapists' self-reporting their own countertransference behaviors. Traditionally, countertransference reports are obtained from supervisors of trainee-therapists or observers/raters in the study. Therapists may not be able to pick up on their own unconscious, unresolved conflicts as they occur in the session. However, there is a small body of literature that provides support for using therapists' ratings of countertransference (Betan. Et al., 2005; Hayes et al., 1997). Furthermore, it was expected that therapists will be able to pick up on and report their own behaviors in session, especially when these behaviors seem inappropriate and unfitting to the situation at hand.

Future research can focus on different perspectives of the components of the tripartite model and session outcome. A growing body of literature has indicated differences in client and therapist perspectives (e.g. Gelso et al., 2012; LoCoco et al., 2011; Ain & Gelso, 2011) and studying therapist-client dyads, as well as observer ratings, can add to our knowledge of the components.

Another limitation of the study lies in its cross-sectional design. It is recognized that the components of the tripartite model of the therapy relationship may change over time, and the design of the present study does not facilitate an exploration of change across the course of therapy. For example, Fuertes et al. (under review) and Gelso et al. (2012) both found changes in patterns as the components unfolded over treatment. In the study at hand, the interest lay in providing an understanding of how the components existed together across theoretical orientations and stages of therapy. Future research, which is longitudinal in nature, may add to the knowledge of the components, in terms of

not just how they unfold, but also the nature of influences. In the current study, associations between the components were studied through correlational analyses. At this point in the study it is not possible to draw conclusions on the directionality of the associations. Longitudinal and experimental research will add to the findings of this study in testing the explanations posited on the influences occurring between the components.

The limitations of the present study allow for an understanding of how future research will be able to add to the findings of the present study. An examination of client and rater perspectives of the components will allow for a deeper understanding of the mechanisms at work. A particularly interesting finding of the present study pertained to the unique contribution of the working alliance and the real relationship on session outcome. More research in this area, perhaps with an examination of possible moderation and mediation models as discussed in the previous sections can illuminate the mechanisms at work in the contribution of the therapy relationship to session outcome.

An unexpected finding in the present study was the absence of the moderation model between transference, emotional insight and session outcome. The role of insight as a moderator in the relationship between negative transference and session outcome is a replicated finding in previous studies (Gelso et al, 1991; Gelso et al., 1997). Thus, the present finding begs the question of under what conditions can we expect this interaction to emerge or disappear. Research in the future can aim to look at transference in more detail to understand its complexity.

Summary, Conclusions, and Implications

Results of the present study add to previous literature, as well as put forth some novel findings. Components of the tripartite model of the therapy relationship were

examined in terms of how they relate to session outcome and each other. Results indicated that the four components relate to session outcome in differing ways. Strong positive associations were seen between the working alliance and session outcome, as well as the real relationship and session outcome, as perceived by therapists. Negative associations were seen between countertransference behaviors and session outcomes, and negative transference and session outcome, as rated by therapists. Results from a simultaneous regression revealed that the working alliance and the real relationship contribute uniquely to session outcome, when all the components are examined together. Perhaps one of the most important findings of the study is that these four components of the therapy relationship (working alliance, real relationship, negative transference and countertransference behaviors) account for 27 percent of the variance in session outcome. This fits with the growing body of data on the therapeutic relationship and treatment outcome (e.g. Norcross, 2012; Norcross, 2002; Lambert & Barley, 2002; Duncan et al., 2010). Norcross and Lambert (2011) have put forth two models that explain what accounts for psychotherapy outcome. The first model deals with the percentages of explained therapy outcome variance, and the second model estimates the percentage of the total (including unexplained variance) of what contributes to therapy outcome. In both the models the therapy relationship plays an important role. The findings of the present study add to this realm of literature by indicating that from the therapist's perspective, the components of the tripartite model contribute to a large amount of variance in session outcome. Results of the study clearly highlight that the components of the tripartite model relate to session outcome, especially when these variables are rated by the therapist. Understanding the negative and positive associations will allow the

therapist to heed to components of the therapy relationship that can both add or be detrimental to session depth, quality and effectiveness. Results of the study also seem to hint that the presence of a strong working alliance and real relationship, in particular, can reduce the negative association between the transferences and session outcome. A message here seems to be the importance of establishing and maintaining a sound working alliance and real relationship with the client.

The second part of the study examined the interrelations among the components of the therapy relationship. As predicted a number of components related to each other, for example, the working alliance, real relationship and transference, as perceived by therapists, relate to one another. The results from this section of the study highlight the relationships among the components. It lends support to Gelso and Samstag's (2008) statement on how the components are distinct, yet interrelated. Support for this postulation is also seen in the third part of the study.

The third part of the study studied the factor structure that emerged following an exploratory factor analysis. Results revealed the presence of four distinct components, bearing strong resemblance to those posited by the tripartite model. Therapists' perceptions of transferences and countertransference behaviors emerged as distinct components. There was a small degree of overlap between the real relationship and the working alliance, however the essential features of the two remained distinct from each other.

Appendix A

Instructions
On the following pages there are sentences that describe some of the different ways a person might think or feel about his or her client. As you read the sentences mentally insert the name of your client in place of _____in the text.
Below each statement inside there is a seven-point scale:

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

If the statement describes the way you always feel (or think) circle the number 7; if it never applies to you circle the number 1. Use the numbers in between to describe the variations between these extremes. Rate the items below with respect to the *last* session with the client.

1._____ and I agree about the steps to be taken to improve his/her situation.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

2._____ and I both feel confident about the usefulness of our current activity in therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

3.I believe _____ likes me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

4.I have doubts about what we are trying to accomplish in therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

5. I am confident in my ability to help _____.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

6. We are working towards mutually agreed upon goals.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

7. I appreciate _____ as a person.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

8. We agree on what is important for _____ to work on.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

9. _____ and I have built a mutual trust.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

10. _____ and I have different ideas on what his/her real problems are.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

11. We have established a good understanding between us of the kind of changes that would be good for _____.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

12. _____ believes the way we are working with her/his problem is correct.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

Appendix B

Insight and Transference--Therapist

Evaluate the items below with respect **to the last session with the client**. Use the following definitions:

Overall insight: The extent to which the client displays an accurate understanding of the material being explored. This understanding may be of the therapy relationship, the client's functioning outside of therapy, or aspects of the client's behavior or personality dynamics. The insight may be intellectual or integrative.

Intellectual (or cognitive) insight is more limited than emotional insight. It demonstrates an understanding, at an intellectual level, of cause and effect relationships, but seems to lack depth because it does not connect to the affects underlying the client's thoughts.

Integrative insight connects intellect and affect. The client is emotionally connected to his/her understanding, even though the insight may be directed at experiences that occurred in the past.

	1 None or slight	2 Some	3 Moderate	4 Much	5 Very much
Overall insight					
Intellectual (cognitive) insight					
Integrative (intellectual + emotional) insight					

Amount of transference: The degree to which the client is dealing with material that is overtly or covertly related to the therapist. This material may be a manifestation of or a displacement from an early important relationship(s). The previous person (or transference source), however, need not be mentioned; he or she may be inferred, and thus transference from him/her to the therapist inferred, because of, for example, the presence of distortion, strong affect, inappropriate affects, etc.

Positive transference is when client feelings toward the therapist and projections onto the therapist are positively valenced.

Negative transference is when client feelings toward the therapist and projections onto the therapist are negatively valenced.

Transference:	1 None or slight	2 Some	3 Moderate	4 Much	5 Very much
Amount					
Positive					
Negative					

Appendix C

Inventory of Countertransference Behavior

On the following scale, please rate your reaction considering the last session with your client.

1	2	3	4	5
to little or no extent		to a moderate extent		to a great extent

I:

_____ 1. Colluded with the client in the session.
_____ 2. Rejected the client in the session.
_____ 3. Oversupported the client in the session
_____ 4. Befriended the client in the session.
_____ 5. Was apathetic toward the client in the session.
_____ 6. Behaved as if I were "somewhere else" during the session.
_____ 7. Talked too much in the session.
_____ 8. Frequently changed the topic during the session.
_____ 9. Was critical of the client during the session.
_____ 10. Spent time complaining during the session.
_____ 11. Treated the client in a punitive manner in the session.
_____ 12. Inappropriately apologized to the client during the session.
_____ 13. Acted in a submissive way with the client during the session
_____ 14. Acted in a dependent manner during the session.
_____ 15. Seemed to agree too often with the client during the session.
_____ 16. Inappropriately took on an advising tone with the client during the session.
_____ 17. Distanced myself from the client in the session.
_____ 18. Engaged in too much self-disclosure during the session.
_____ 19. Behaved as if I were absent during the session.
_____ 20. Inappropriately questioned the client's motives during the session.
_____ 21. Provided too much structure in the session.

Appendix D

The Real Relationship Inventory—Therapist Form

Please complete the items below in terms of your relationship with your client or patient in the last session. Use the following 1–5 scale in rating each item, placing your rating in the space adjacent to the item.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

____ 1. My client is able to see me as a real person separate from my role as a therapist.
____ 2. My client and I are able to be genuine in our relationship.
____ 3. My client feels liking for the "real me."
____ 4. My client genuinely expresses his/her positive feelings toward me.
____ 5. I am able to realistically respond to my client.
____ 6. I hold back significant parts of myself.
____ 7. I feel there is a "real" relationship between us aside from the professional relationship.
____ 8. My client and I are honest in our relationship.
____ 9. My client has little caring for who I "truly am."
____ 10. We feel a deep and genuine caring for one another.
____ 11. My client holds back significant parts on him/herself.
____ 12. My client has respect for me as a person.
____ 13. There is no genuinely positive connection between us.
____ 14. My client's feelings toward me seem to fit who I am as a person.
____ 15. I do not like my client as a person.
____ 16. I value the honesty of our relationship.
____ 17. The relationship between my client and me is strengthened by our understanding of one another.
____ 18. It is difficult for me to express what I truly feel about my client.
____ 19. My client has unrealistic perceptions of me.
____ 20. My client and I have difficulty accepting each other as we really are.
____ 21. My client distorts the therapy relationship.
____ 22. I have difficulty being honest with my client.
____ 23. My client shares with me the most vulnerable parts of him/herself.
____ 24. My client genuinely expresses a connection to me.

Appendix E

Session Evaluation Scale

For the most recent session my client:	Strongly Disagree				Strongly Agree
1. is glad he/she attended this session	1	2	3	4	5
2. did *not* feel satisfied with what he/she got out of this session	1	2	3	4	5
3. thought that this session was helpful	1	2	3	4	5
4. did *not* think that this session was valuable	1	2	3	4	5

5. Rate the overall effectiveness of this session

Not effective				Highly effective
1	2	3	4	5

Single item for session quality

Please rate the overall quality of the last sessions with your client using the following scale:

Very poor	Poor	Neutral	Good	Very Good
1	2	3	4	5

Appendix F

Session Evaluation Questionnaire- Depth

Please place an 'X' on each line to show how you feel about this session

This session was:

Shallow						Deep
1	2	3	4	5	6	7
Worthless						Valuable
1	2	3	4	5	6	7
Empty						Full
1	2	3	4	5	6	7
Weak						Powerful
1	2	3	4	5	6	7
Ordinary						Special
1	2	3	4	5	6	7

Appendix G

Demographic Questionnaire for Therapists

1. Gender

2. Age

3. Ethnic Background
___ African American/Black
___ Caucasian/White
___ Asian/Pacific Islander
___ Hispanic/Latino
___ Other (Specify

2. Most Advanced degree
___ BA/BS
___ MA/MS
___ PhD
___ Other (specify)

3. Your Theoretical Approach

Please write the number that best indicates how representative each of the following approaches is of your work in psychotherapy

Strongly Representative	**Moderately**	**Neutral**	**Just a Little**	**Not at all**
5	**4**	**3**	**2**	**1**

___ Humanistic/Experiential
___ Psychodynamic/Psychoanalytic
___ Cognitive/Behavioral
___ Systems
___ Other

4. Approximate amount of sessions with the client (your best estimate)

5. Years of clinical experience: To your best estimate, please write how many years you have been providing therapy (post graduate degree)

Appendix F

First letter to therapists

Subject: A Hopeful Plea

Dear Dr. _____,

I greatly appreciate your taking the time to read this letter. I am writing to you because of your involvement in psychotherapy. If you are not currently seeing clients or patients, please respond to this email letting me know that you are not seeing clients and I will not contact you further. If you do currently see clients or patients for individual psychotherapy, please read on.

I would be very grateful if you will consider participating in a study that I am conducting for my thesis under the supervision of my advisor, Dr. Charles Gelso. We are studying aspects of the therapeutic relationship between client and therapist. We hope to gain valuable insight into this important piece of psychotherapy; however, in order to do so we really need your help. Your participation is greatly needed and would be incredibly helpful and appreciated.

This research would involve approximately 20 minutes of your time to complete some measures. We are aware that your time is extremely important, but believe that the nature of this research will make your participation worthwhile. All participants will receive a summary of our findings and be notified of any publications that result from this study.

If you are agreeable to participating in the study and are working with a client with whom you have had at least 5 sessions and who is at least 18 years old, please follow the link attached in this email. Please fill the measures based on your *most recent session* with the *last* client you have seen for at least 5 sessions. At this point, I would be happy to discuss the study further and answer any questions you might have. Again, thank you in advance for taking out the time to participate in my study.

This study has received IRB approval from The University of Maryland. If you are willing to participate please follow the link below. For any questions regarding this study, please contact Avantika Bhatia at abhatia6@umd.edu or 240-264-9681.

Link: https://umd.us2.qualtrics.com/SE/?SID=SV_8AhMqBbk3L00bkg

Thank you.

Sincerely,

Avantika Bhatia, M.A.

Dr. Charles J. Gelso, Phd

Appendix G

Reminder 1 to Therapists

Dear_____,

We recently sent you a request for your assistance in a study we are conducting. We have not heard from you and wanted to send you a reminder about your participation. We will be deeply appreciative if you will be willing to participate in the study. Included below is the request that we sent you for the study.

If do not wish to participate, please respond to this email and we will no longer contact you.

Sincerely,

Avantika Bhatia, M.A.
University of Maryland, College Park

Charles J. Gelso, PhD
Professor of Psychology

Thank you so much for taking the time to read this letter. I am writing to you because of your involvement in psychotherapy. If you are not currently seeing clients or patients, please respond to this email letting me know that you are not seeing clients and I will not contact you further. If you do currently see clients or patients for individual psychotherapy, please read on.

I would be very grateful if you will consider participating in a study that I am conducting for my thesis under the supervision of my advisor, Dr. Charles Gelso. We are studying aspects of the therapeutic relationship between client and therapist. We hope to gain valuable insight into this important piece of psychotherapy; however, in order to do so we really need your help. Your participation is greatly needed and would be incredibly helpful and appreciated.

This research would involve approximately 20 minutes of your time to complete some measures. We are aware that your time is extremely important, but believe that the nature of this research will make your participation worthwhile. All participants will receive a summary of our findings and be notified of any publications that result from this study.

If you are agreeable to participating in the study and are working with a client with whom you have had at least 5 sessions and who is at least 18 years old, please follow the link attached in this email. Please fill the measures based on your *most recent session* with the *last* client you have seen for at least 5 sessions. At this point, I would be happy to discuss the study further and answer any questions you might have. Again, thank you in advance for taking out the time to participate in my study.

This study has received IRB approval from The University of Maryland. If you are willing to participate please follow the link below. For any questions regarding this study, please contact Avantika Bhatia at abhatia6@umd.edu or 240-264-9681.

Link:----------

Thank you.

Sincerely,

Avantika Bhatia, M.A.
Phone: 240-264-9681
Email: abhatia6@umd.edu

Dr. Charles J. Gelso, Phd
Professor of Psychology

Reminder 2: Same as Reminder 1

Appendix H

Reminder 3 to Therapists

Reminder 3:

Dear_____,

We are following up on my earlier requests for your assistance in a study we are conducting. We are sorry to bother you again with this email. We are trying to increase the sample size for the study and would really appreciate your help. Included below is the request that we sent you for the study.

If do not wish to participate, please respond to this email and we will no longer contact you.

Sincerely,

Avantika Bhatia, M.A.
University of Maryland, College Park

Charles J. Gelso, PhD
Professor of Psychology

Thank you so much for taking the time to read this letter. I am writing to you because of your involvement in psychotherapy. If you are not currently seeing clients or patients, please respond to this email letting me know that you are not seeing clients and I will not contact you further. If you do currently see clients or patients for individual psychotherapy, please read on.

I would be very grateful if you will consider participating in a study that I am conducting for my thesis under the supervision of my advisor, Dr. Charles Gelso. We are studying aspects of the therapeutic relationship between client and therapist. We hope to gain valuable insight into this important piece of psychotherapy; however, in order to do so we really need your help. Your participation is greatly needed and would be incredibly helpful and appreciated.

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If you are agreeable to participating in the study and are working with a client with whom you have had at least 5 sessions and who is at least 18 years old, please follow the link attached in this email. Please fill the measures based on your *most recent session* with the *last* client you have seen for at least 5 sessions. At this point, I would be happy to discuss

the study further and answer any questions you might have. Again, thank you in advance for taking out the time to participate in my study.

This study has received IRB approval from The University of Maryland. If you are willing to participate please follow the link below. For any questions regarding this study, please contact Avantika Bhatia at abhatia6@umd.edu or 240-264-9681.

Link:----------

Thank you.

Sincerely,

Avantika Bhatia, M.A.
Phone: 240-264-9681
Email: abhatia6@umd.edu

Dr. Charles J. Gelso, Phd
Professor of Psychology

Appendix I

Table 6

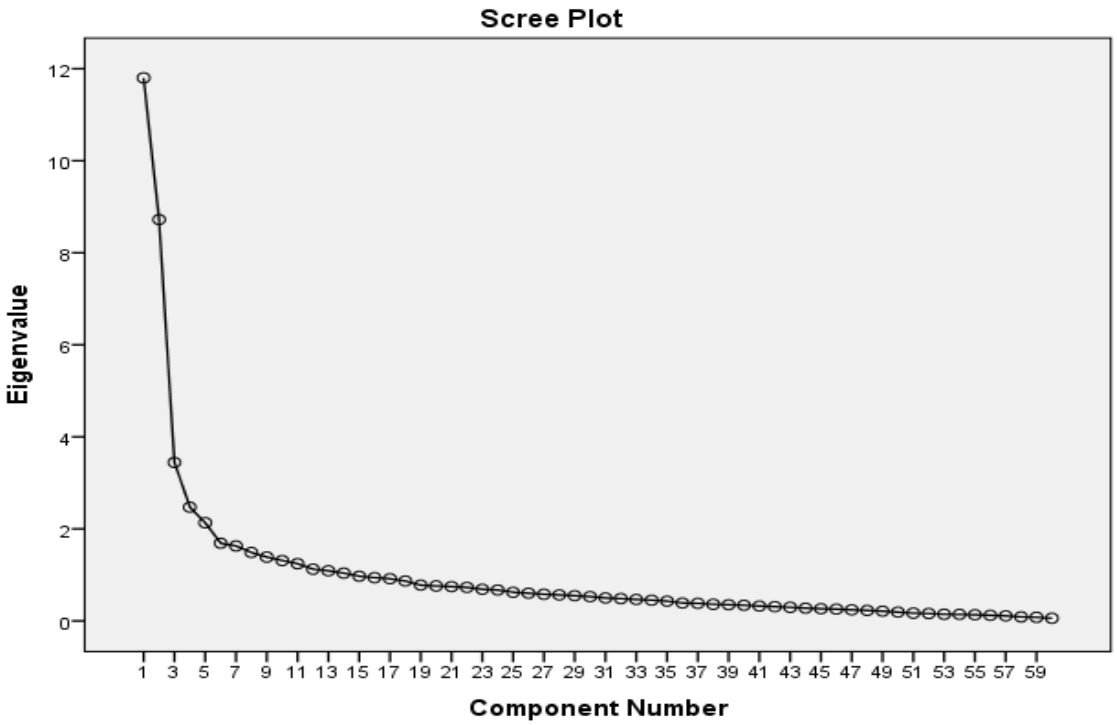
Results of parallel analysis: Raw Data Eigenvalues, & Mean & Percentile Random Data Eigenvalues

Root	Raw Data	Means	Percentile
1.000000	**11.404012**	**2.414267**	**2.550577**
2.000000	**9.429916**	**2.274544**	**2.383780**
3.000000	**3.897756**	**2.178205**	**2.271305**
4.000000	**2.503841**	**2.084771**	**2.157547**
5.000000	2.036770	2.009846	2.075802
6.000000	1.776199	1.937386	1.990455
7.000000	1.593963	1.871517	1.928602
8.000000	1.494645	1.807576	1.865081
9.000000	1.412258	1.751777	1.793673
10.000000	1.342800	1.692802	1.741288
11.000000	1.234210	1.638836	1.691727
12.000000	1.143209	1.592824	1.631692
13.000000	1.076311	1.541448	1.578496
14.000000	1.046046	1.491014	1.534916
15.000000	.979153	1.445714	1.493338
16.000000	.937839	1.399876	1.433405
17.000000	.882595	1.357390	1.394708
18.000000	.828521	1.318453	1.361667
19.000000	.813211	1.277004	1.314247
20.000000	.756406	1.240853	1.284720
21.000000	.736048	1.200960	1.240961
22.000000	.714545	1.163877	1.196171
23.000000	.675792	1.131683	1.167531
24.000000	.654371	1.095563	1.129269
25.000000	.615608	1.062210	1.092808
26.000000	.587347	1.029936	1.061260
27.000000	.580761	.995676	1.030034
28.000000	.553698	.961627	.992010
29.000000	.522549	.932789	.958756
30.000000	.501992	.899360	.932029
31.000000	.483940	.868297	.896960
32.000000	.446606	.839062	.864584
33.000000	.440551	.810583	.841317
34.000000	.430618	.783090	.812517
35.000000	.404792	.753001	.785601
36.000000	.391347	.726327	.750806
37.000000	.371992	.699962	.728691

38.000000	.349655	.672735	.693949
39.000000	.330172	.646156	.666162
40.000000	.322008	.623490	.644655
41.000000	.284879	.600145	.629501
42.000000	.271992	.577718	.604036
43.000000	.260239	.554731	.579786
44.000000	.250935	.530920	.560299
45.000000	.236714	.507342	.531730
46.000000	.224411	.484219	.506278
47.000000	.217998	.460766	.485049
48.000000	.185230	.438560	.463394
49.000000	.174460	.416363	.440875
50.000000	.158214	.396365	.426326
51.000000	.142506	.373668	.398210
52.000000	.135511	.355131	.376876
53.000000	.129109	.332662	.355983
54.000000	.119947	.313255	.333342
55.000000	.114512	.294019	.315055
56.000000	.110851	.272892	.292840
57.000000	.094074	.251258	.271934
58.000000	.080647	.229675	.253207
59.000000	.066175	.206028	.228053
60.000000	.037544	.181798	.203681

Appendix J

Scree plot from an Exploratory Factor Analysis



Correlation matrix

	1	2	3	4	5	6	7	8	9	10	11	12
1. Session Outcome total	1											
2. SES	0.72**	1										
3. SEQ	0.87**	.41**	1									
4. RRI	.42**	.48**	.32**	1								
5. WAI	.50**	.52**	.38**	.63**	1							
6. ICB_tota	-0.18**	-0.05	-.11*	-.10	-.30**	1						
7. ICB_Neg	-0.24**	-0.11*	-0.12*	-0.13*	-.32**	.83**	1					
8. ICB_pos	-.24**	-.00	-.01	-.04	-.25**	.80**	.54**	1				
9.Trans_neg	-0.13*	-.25**	-.06	-.20**	-.25**	.11	.13*	.18**	1			
10. Trans_total	-0.06	-0.09	-0.02	0.01	-0.12*	0.11	0.14*	.18**	.37**	1		
11. Trans_pos	-0.01	-0.01	.00	.14*	0.00	0.08	0.08	0.1	.17**	.73**	1	
12. Emotional Insight	.52**	.51**	.40**	.53**	.52**	-.13*	-0.1	-.18*	-.14*	-0.07	0.05	1

Note: Session outcome= Session Evaluation Scale + Session Evaluation Questionnaire- Depth subscale; SES= Session Evaluation Scale; SEQ= Session Evaluation Questionnaire-Depth; WAI=Therapist ratings of the Working Alliance Inventory-Short form; RRI=Therapist ratings of the Real Relationship Inventory; ICB_total = log transformations of therapist ratings of the Inventory of Countertransference Behavior; ICB_negative = log transformations of therapist ratings of the negative subscale of the Inventory of Countertransference Behavior; Trans_total= Theapist ratings of amount of transference;

Trans_neg = = log transformation of therapist ratings of negative transference; Trans_pos= Therapist ratings of positive transference

**p<.05. **p<.01.*

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