

ABSTRACT

Title of thesis: WOMEN COUNSELORS' COUNTERTRANSFERENCE
REACTIONS TO WOMEN CLIENTS WITH BODY IMAGE
DISTURBANCE

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Women may seek counseling for body image concerns because such concerns are common in society. Women counselors may also suffer from body image disturbance, however. Countertransference is a threat to a counselor's ability to help a client and occurs when client presenting style and/or problem taps into unresolved counselor issues.

Women counselors' countertransference reactions to women clients with body image concerns were investigated in light of counselors' body image concerns and client physique in an audiovisual analogue counseling session. Counselors interacted with a video of a woman client discussing body image concerns. Client physique was manipulated such that counselors saw either a client whose physique was close to or far from the societal ideal.

No significant relationships were found between the two independent variables (counselor body image disturbance and client physique) and countertransference. The nonsignificant findings are discussed in the context of the low body image disturbance in the sample.

WOMEN COUNSELORS' COUNTERTRANSFERENCE REACTIONS TO WOMEN
CLIENTS WITH BODY IMAGE DISTURBANCE

by

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CHAPTER 1

INTRODUCTION

Body image is a broad, multidimensional construct that includes perception of, affect toward, cognitions about, and behaviors aimed at changing one's body (Banfield & McCabe, 2002). A person is said to have a positive body image when he or she perceives his or her body accurately, feels and thinks positively about his or her body's appearance, and does not engage in inappropriate behaviors such as purging or extreme dieting to change the way he or she looks. A person suffers from body image disturbance, however, when he or she misperceives his or her body's shape, feels and thinks negatively about his or her body, or engages in inappropriate behaviors to change his or her body's size and/or shape.¹

Unfortunately, many people in today's society, particularly women, are dissatisfied with their bodies. Societal pressures to look a certain way are extreme. Garner, Garfinkel, Schwartz, and Thompson (1980) conducted a study looking at the percentage of space in popular women's magazines devoted to diet between 1959 and 1978. They found that over the years this percentage has steadily increased. Women are increasingly being encouraged to change their appearance to conform to an ideal standard of beauty. Yet, just as the pressure to conform to this standard has increased in recent years, so has the thinness of this standard. Today's beauty icons as exemplified by movie stars such as Gwyneth Paltrow and models such as Kate Moss are much thinner and fitter

¹ People who are over- or underweight may have good reason to feel and think negatively about their bodies. They may engage in appropriate behaviors to change the size and/or shape of their bodies (e.g., dieting if they are overweight or eating high-calorie foods if they are underweight). For these people, a negative body image may not indicate a disturbance but rather appropriate reality-testing. However, misperception of body size or engaging in inappropriate, unhealthy behaviors to change body size and/or shape (e.g., bingeing or purging) may still be indicative of a body image disturbance for over- or underweight women.

than beauty icons of the past like Marilyn Monroe or Mae West. Garner and his colleagues (1980) also found empirical evidence for this thinner standard by examining the measurements, heights, and weights of *Playboy* centerfolds and Miss America pageant winners between 1959 and 1978. They found a significant trend toward a thinner standard of beauty.

Research has further shown that some of the variance in body image dissatisfaction experienced by women and teenage girls can be accounted for by exposure to media images, although we cannot be certain of the direction of causality (e.g., Botta, 2003). Indeed, Botta found that from 23.4 to 41.6 percent of the variance in girls' anorexic and bulimic behaviors, drive to be thin, and body satisfaction was accounted for both by the amount of time girls spent looking at women's fashion and health/fitness magazines and by how girls processed the magazines' content. The more time girls spent comparing themselves to models, the more likely they were to have increased anorexic and bulimic behaviors, increased drive to be thin, and decreased body satisfaction. As mentioned above, the amount of content in women's magazines that focuses on diet is increasing (Garner et al., 1980). Magazines often pair these articles with pictures of attractive, thin models. This pairing of articles and images not only increases the pressure to be thin, but also provides a nearly impossible standard with which to compare.

Posavac, Posavac, and Posavac (1998) found that exposure to media images of attractive women increases women's concern about their own weight even in non-body image-related settings, such as when pictures of attractive models are shown to women without captions or accompanying articles in a laboratory setting. Botta (2000) has examined the effect of television watching on girls' body image and found similarly

detrimental effects. Thus, it seems natural to extend these findings: the more time women spend immersed in popular culture in general, the more dissatisfied they are with their bodies. Unfortunately, for many women, popular culture is inescapable. Researchers have termed this pervasive, culturally induced body image disturbance the “normative discontent” (Rodin, Silberstein, & Striegel-Moore, 1984).

Not only are women unhappy with their bodies, they are increasingly going to extreme measures to change their bodies. Studies have found that as many as 61 percent of college-aged women engage in disordered eating behaviors, that is inappropriate behaviors aimed at changing one’s body weight and/or shape (Mintz & Betz, 1988). In fact, frequently engaging in such behaviors is one of the criteria for a DSM-IV-R diagnosis of anorexia nervosa or bulimia nervosa (American Psychiatric Association, 2000). Even women who do not meet the criteria for a diagnosable eating disorder, however, suffer psychological distress as a result of body image disturbance in the form of low self-esteem, depression, and neuroticism (Tylka & Subich, 1999). Clearly, the pressure to be thin in today’s society has serious consequences for mental and physical health.

Not all women are dissatisfied with their body image. Posavac et al. (1998) posit that women whose appearance is close to that of the media ideal or women who derive a great deal of self-esteem from other, important parts of their lives are, in a sense, immune to societal pressure. They found that women who were low on body image dissatisfaction did not experience a negative change in concern about weight after viewing slides of attractive models. Thus, these women may not experience the distress associated with body image dissatisfaction. However, few women are close to the ideal in their own

appearance. What is more, many women, even those who are highly competent in other areas of their lives, still believe that physical appearance is an important aspect of their self-worth. Researchers have even found empirical evidence for this belief in that for women, physical attractiveness greatly influences social outcomes (e.g., Buss, 1994; Feingold, 1990). Although there are exceptions to the “normative discontent,” many women still experience distress associated with their body image.

Several researchers have theorized that social comparison is responsible for the effect of media exposure on women’s body image dissatisfaction (e.g., Botta, 2003; Heinberg & Thompson, 1992; Wood, 1989). Social comparison theory suggests that when people compare themselves to those who are superior on a given dimension, they report increases in negative affect and decreases in self-esteem (Festinger, 1954). Conversely, when people compare themselves to those who are inferior, they experience increased positive affect and self-esteem. Media images of the ideal body may have their detrimental effect on women’s body image by encouraging comparison. For most women, comparison to the retouched pictures of extremely thin models they see in magazines equals an inevitably upward comparison; they are comparing themselves to women who are superior to them on the dimension of physical beauty. They see themselves as inferior to the models and therefore experience an increase in negative affect and decrease in self-esteem.

Social comparison also extends beyond the realm of comparison to media images. Jones (2001) found that adolescents compare themselves to peers on several dimensions of physical attractiveness, including weight and body shape, and that these comparisons often result in decreases in body satisfaction. Studies of college women also support these

findings (e.g., Hausenblas, Janelle, Gardner, & Hagan, 2002). Researchers have found that women who engage in more appearance-related social comparisons both to media images and peers are more likely to be dissatisfied with their body image (Faith, Leone, & Allison, 1997; Stormer & Thompson, 1996; Thompson, Coover, & Stormer, 1999).

It seems reasonable to conclude that women who are dissatisfied with their body image might seek counseling as a result of the associated psychological distress. Thus, it is imperative that counselors are able competently to help women with body image concerns. Unfortunately, Dworkin and Kerr (1987) state, “Too often counselors maintain the status quo, reinforcing dieting instead of body acceptance” (p. 137). I posit that a central reason for women counselors’ “maintenance of the status quo” is that many women counselors also have unresolved body image concerns. Women counselors are not immune to the pervasive nature of body image disturbance in society. I agree with Dworkin and Kerr: “The first step that counselors might take is to explore their own irrational beliefs about body image and to change those beliefs to more rational beliefs fostering acceptance of women of all shapes.” However, because of the “normative discontent” and the continual bombardment of popular culture on all women, including counselors, it seems unlikely that many women counselors have fully explored their beliefs about their own body image.

A serious threat to the ability of counselors to help clients effectively is countertransference. Countertransference occurs in a counseling session when client presenting style or presenting problem hits upon unresolved conflict or vulnerabilities in the counselor. Thus, when a client’s concerns overlap with unresolved counselor issues, the counselor is likely to experience countertransference. Effective countertransference

management is related to a host of positive factors, such as perceived excellence as a therapist (Van Wagoner, Gelso, Hayes, and Diemer, 1991), modulation of countertransference behavior in therapy (Hayes, Riker, & Ingram, 1995), and positive counseling outcomes (Gomez, Gelso, Fassinger, & Latts, 1995). For counselors who are not able to manage their countertransference, however, the countertransference often interferes with their ability to be effective in the session.

Affective, cognitive, and behavioral countertransference reactions have been particularly studied. Affective countertransference reactions can take the form of increased state-anxiety (e.g., Gelso et al., 1995; Hayes & Gelso, 1991, 1993; Sharkin & Gelso, 1993); cognitive countertransference reactions are manifested as distortion (i.e., incorrect recall) of client material (e.g., Cutler et al., 1958; Gelso, Fassinger, Gomez, & Latts, 1995; Hayes & Gelso, 1993); and behavioral countertransference reactions include avoidance of or withdrawal from (e.g., Bandura, Lipsher, & Miller, 1960; Hayes & Gelso, 1993) or overinvolvement with (e.g., Gelso et al., 1995) client material. All three types of countertransference reactions may interfere with the counselor's effectiveness in the session and may lead to negative counseling outcomes.

The high likelihood of unresolved body image concerns in women counselors suggests that women counselors may well experience countertransference with women clients with body image concerns. Hausenblas, Janelle, Gardner, and Hagan (2002) found that during exposure to slides both of themselves and of attractive female college students, women college students who were dissatisfied with their body image experienced decreased pleasure. A counselor with body image concerns who is presented with a client whose body type is similar to the societal ideal may similarly experience

decreased pleasure in the session. This reaction may be particularly pronounced if the client is actively talking about her own body image. If a counselor were to experience decreased pleasure or increased anxiety in response to a client's appearance and presenting problem, this reaction could be seen as an affective countertransference reaction.

It is therefore important to investigate the relationship between counselor body image satisfaction and countertransference. What is more, a further step is to investigate what kinds of women clients with body image concerns are likely to trigger countertransference reactions in women counselors. I theorize that clients with body image concerns whose physiques are close to the societal ideal are more likely to trigger countertransference reactions in counselors than are clients whose physiques are far from the societal ideal. As discussed above, women with low body image disturbance may not experience an increase in concern about their weight after viewing slides of attractive models for two reasons. They might not go through the social comparison process that leads to a negative self-evaluation, or their social comparison process might not result in a negative self-evaluation. However, for women who have high body image disturbance, social comparison and negative self-evaluations play a particularly important role in concerns about body image. The more the client conforms to the societal ideal, the more likely it is that the social comparison process will lead to a negative self-evaluation. In accordance with social comparison theory, this negative self-evaluation will lead to increased negative affect and decreased self-esteem in counselors. Thus, when presented with a client who is close to the ideal, counselors may experience more countertransference than when presented with a client who does not conform to the ideal.

A client whose physique is close to the societal ideal may have legitimate body image concerns, however. Women's perception of their bodies is often highly distorted. Gray (1977) found that women who misperceive their body size consistently see themselves as heavier than they are, and women diet more than men even though they are more likely than men to be underweight. Furthermore, Casper, Halmi, Goldberg, Eckert, and Davis (1979) found no difference in the degree of body image disturbance between normal weight control women and anorexic women. Thus, a woman whose physique is close to the ideal and is suffering from body image disturbance may not see herself as closer to the ideal than a woman whose physique is objectively farther from the ideal. It seems reasonable to conclude that clients whose physiques are close to the societal ideal experience the same amount of subjective psychological distress from body image disturbance as clients whose physiques are far from the ideal. Both groups of clients should therefore receive similar counseling interventions.

Counseling psychologists are frequently likely to encounter women clients with body image disturbance. Understanding if and how countertransference occurs in these dyads is imperative if counseling psychologists are effectively to help this population. The present study attempts to understand women counselors' countertransference reactions to women clients with body image concerns in the context of the counselors' own body image disturbance and the objective physical appearance of the client.

CHAPTER 2

REVIEW OF THE LITERATURE

The purpose of the present study is to examine the effects of women counselors' body image on their countertransference to women clients. In particular, countertransference to women clients whose physiques are both close to and far from the societal ideal will be assessed. Body image disturbance is rampant among women in American society (e.g., Cash & Henry, 1995). It is therefore likely that many women clients and counselors suffer from body image concerns. Women counselors with body image problems may experience countertransference when working with a client presenting with body image concerns. This countertransference may be especially heightened when the client's physique is close to the societal ideal. No research has investigated the effects of counselor body image and client physique on countertransference. However, there is an abundance of literature on body image, and there is an abundance of literature on countertransference. To explore how these two constructs may be related, I will review the literature in two sections. First, I will focus on body image, particularly its definition, the consequences and prevalence of body image disturbance, and the social comparison theory of body image disturbance. Second, I will review the literature on countertransference, including the historical development of the construct and Hayes's (1995) five-factor model of countertransference.

Body Image

Definition of Body Image

Although researchers have studied the construct of body image for decades, there is little consensus about its definition. Originally conceptualized as a unidimensional

construct, researchers now view body image as multidimensional; however, just what makes up these dimensions is open to debate. Among the proposed dimensions of body image are: perception (e.g., Cash, 1994; Ruff & Barrios, 1986), attitude (e.g., Brown, Cash, & Mikulka, 1990; Franzoi & Shields, 1984), cognition, behavior, affect (e.g., Cash & Pruzinsky, 1990), fear of fatness, body distortion (e.g., Banfield & McCabe, 2002), body dissatisfaction (e.g., Garner, Olmstead, & Polivy, 1983), avoidance (e.g., Rosen, Srebnik, Saltzberg, & Wendt, 1991), preoccupation (e.g., Cooper, Taylor, Cooper, & Fairburn, 1987; Mazzeo, 1999), drive for thinness, and restrictive eating (e.g., Garner, Olmstead, & Polivy, 1983).

Many researchers' definitions of body image take into account several but not all of the above dimensions, and the measures of body image selected by different researchers for use in studies reflect their differing definitions. For example, Slade (1994) proposed that body image is "a loose mental representation of body shape, size and form which is influenced by a variety of historical, cultural and social, individual, and biological factors, which operate over varying time spans" (p.302). Cash and Pruzinsky (1990) see body image as composed of self-attitudes toward one's body, where self-attitudes include self-perceptions of, cognitions about, affect toward, and behaviors aimed at changing one's body. Cash and his colleagues' definition of body image is reflected in the measure they often use to assess body image, the Body-Self Relations Questionnaire (BSRQ; Brown, Cash, & Mikulka, 1990; Cash, 1990; Cash, Winstead, & Janda, 1985, 1986).

What dimensions researchers include in their definitions of body image are also influenced by the purpose of their research. For example, researchers interested in

studying the influence of body image disturbance on the development of eating disorders have attempted to isolate the dimensions of body image that discriminate non-clinical from clinical populations of women (Mazzeo, 1999). One's perception of one's body, although seen by many researchers as an important dimension of body image, does not differentiate women with eating disorders from women without eating disorders. In fact, Casper, Halmi, Goldberg, Eckert, and Davis (1979) found no difference in the degree of body misperception between control subjects and women with anorexia nervosa. Similarly, the attitudinal dimension of body image, defined as one's overall satisfaction with one's shape, does not clearly differentiate clinical from control samples. Although negative attitudes toward one's body are a central component of eating disorders, many women without eating disorders also appear to have negative attitudes about their bodies (e.g., Rodin, Silberstein, & Striegel-Moore, 1985).

The strength of the negative attitudes about one's body, operationalized as one's preoccupation with one's body, however, has been shown to discriminate between women with and without eating disorders (e.g., Mazzeo, 1999). Rosen, Srebnik, Saltzberg, and Wendt (1991) found that a measure of behavioral avoidance (i.e., avoidance of physical intimacy because of concern over physical appearance) discriminated between women with bulimia nervosa and controls. Thus, for researchers concerned with the effects of body image on the development of eating disorders, preoccupation and behavioral avoidance may be particularly salient dimensions of body image.

Researchers interested in body image disturbance in the general population have focused on dimensions such as perception, cognition, affect, and behavior (e.g., Cash &

Henry, 1995). Noles, Cash, and Winstead (1985) found a relationship between these four dimensions as assessed by the Body-Self Relations Questionnaire (BSRQ; Brown, Cash, & Mikulka, 1990; Cash, 1990; Cash, Winstead, & Janda, 1985, 1986) and depression in a non-clinical sample. Dimensions of body image that go beyond preoccupation may be of interest when assessing body image in the general population. This is so because of the relationship in non-clinical samples between body image as defined by Cash and his colleagues and mental health.

This disagreement over what exactly comprises body image and how it should be measured has two important consequences. First, it is difficult to compare results of studies using different conceptual and operational definitions of body image. Second, and perhaps more insidiously, if no consensus can be reached on how to define body image, then little consensus can be expected on how to treat negative body image in clients.

Banfield and McCabe (2002) reviewed past conceptualizations of body image and concluded that, consistent with Cash and his colleagues, many definitions have incorporated at least one of the following dimensions: perception, cognition, affect, and behavior. The perceptual dimension of body image is defined as one's judgment of one's size and shape relative to one's actual size and shape (Cash, Wood, Phelps, & Boyd, 1991; Slade, 1994). Gray (1977) found that women and girls who misperceive their body size consistently see themselves as heavier than they are. The cognitive dimension of body image is defined as one's thoughts and beliefs concerning one's body; and the affective dimension is conceptualized as the feelings one has toward one's body (Cash & Green, 1986). Many measures include both affective and cognitive questions (e.g., the

Body Dissatisfaction Subscale of the Eating Disorder Inventory; Garner, Olmstead, & Polivy, 1983) and use these dimensions interchangeably.

The behavioral dimension of body image includes dieting, extreme weight loss measures (e.g., vomiting, using laxatives), and avoidance behaviors (e.g., wearing baggy clothing). Such behaviors are commonly associated with eating disorders. Some researchers have argued that behaviors aimed at changing one's shape or avoiding situations in which one's appearance becomes salient are a consequence of negative body image (e.g., Gleaves, Williamson, Eberenz, Sebastian, & Barker, 1995). However, the commonly accepted view is that behaviors associated with body image may occur concurrently with distorted perception, affect, and cognition, or may influence these dimensions (e.g., Tiggemann, 1994). What is more, Cash and his colleagues' conceptualization of body image as self-attitudes is consistent with including behavior in a definition of body image. The social-psychological definition of an attitude includes cognitive, affective, and behavioral components (Shaver, 1981). Studies have shown an empirical distinction between one's attitudes toward and perception of one's body when attitude is defined in this way (e.g., Cash & Brown, 1987; Garner & Garfinkel, 1981). Thus, behavior seems to be an important dimension of body image.

Banfield and McCabe (2002) investigated a four-factor model of body image that included the four dimensions described above: perception, cognition, affect, and behavior. They used a scale comprised of items pulled from ten commonly used measures of body image that assessed each of these four dimensions. Factor analysis revealed three dimensions, which Banfield and McCabe titled Cognitions and Affect Regarding Body, Body Importance and Dieting Behavior, and Perceptual Body Image. These three factors

are somewhat consistent with previous conceptualizations of body image (e.g., Brown, Cash, & Mikulka, 1990; Ben-Tovim & Walker, 1991; Cash, 1994). What is more, they make good conceptual sense. As mentioned previously, many researchers lump cognitions and affect together. Behavior is seen as separate from cognitions and affect and includes an investment component. Namely, how invested one is in one's appearance influences the extent to which one engages in weight loss or avoidance behaviors. Lastly, consistent with the empirical distinction described above, perception is seen as distinct from cognitions, affect, and behavior.

Consequences and Prevalence of Body Image Disturbance

Although researchers have a difficult time deciding on a definition of body image, they agree on two things. First, body image disturbances are related to a host of negative psychological factors. Second, negative body image is frighteningly common among American women.

Negative body image is one of the most important features of eating disorders. Indeed, body image disturbance, defined as “disturbance in the way in which one's body weight or shape is experienced [and] undue influence of body weight or shape on self-evaluation,” is one of the necessary criteria for a clinical diagnosis of anorexia nervosa or bulimia nervosa (American Psychiatric Association, 1994). The first part of this criterion, “disturbance in the way in which one's body... is experienced” can be likened to a disturbance in perception, whereas “undue influence” can be seen as body image preoccupation. What is more, weight and shape-changing behaviors included in the behavioral dimension of body image such as restrictive eating and purging are also

included in DSM-IV criteria for anorexia nervosa and/or bulimia nervosa (American Psychiatric Association).

As described above, many researchers have successfully used measures of body image to discriminate between women with and without eating disorders. Both the Body Shape Questionnaire-R-10 (Cooper, Taylor, Cooper, & Fairburn, 1987; Mazzeo, 1999), which assesses body image preoccupation, and the Body Image Avoidance Questionnaire (Rosen, Srebnik, Saltzberg, & Wendt, 1991), which assesses avoidance behavior, have been shown to differentiate between clinical and control samples. Thus, women who are preoccupied with their bodies and engage in avoidant behaviors are more likely than less preoccupied and avoidant women to be diagnosed with an eating disorder.

The attitudinal dimension of body image is also related to eating disorders. Researchers have found that women with eating disorders have more negative attitudes toward their bodies than women without eating disorders (e.g., Brown, Cash, & Lewis, 1989). Stice, Schupak-Neuberg, and Shaw (1994) found that body satisfaction as measured by the Body Dissatisfaction subscale of the Eating Disorders Inventory (Garner, Olmstead, & Polivy, 1983), a primarily affective and cognitive measure of body image, mediates the effect of internalization of the media's thin ideal (to be discussed later) on eating disorder symptomology. Their results are consistent with those of Striegel-Moore, Silberstein, and Rodin (1986), who found that body satisfaction predicts eating disorder symptomology. In a two-year longitudinal study of adolescent girls, Attie and Brooks-Gunn (1989) found that eating problems at Time 1 were associated with negative body image at Time 1. Negative body image at Time 1 also predicted eating

disorder symptomology two years later. Thus, it is clear that body image disturbances influence, and are a central component of, eating disorders.

Body image disturbances also have a negative impact on the mental health of women without eating disorders. Noles, Cash, and Winstead (1985) found that depressed subjects were less satisfied with their bodies and saw themselves as less attractive than non-depressed subjects. In the study described above, Attie and Brooks-Gunn (1989) found a positive relationship between eating problems, body dissatisfaction, and global measures of psychopathology, including depressive symptomology. The perceptual dimension of body image is also associated with mental health. McCreary and Sadava (2001) found that women who perceived themselves as heavier reported lower life satisfaction than those who perceived themselves as lighter. In sum, women with body image disturbances who do not meet the criteria for an eating disorder still suffer psychological distress in the form of low self-esteem, depression, and neuroticism (Tylka & Subich, 1999).

Considering the negative impact of body image disturbances on mental health, it seems essential to know how many individuals are afflicted with negative body image. Many researchers have investigated the prevalence of negative body image, and the results are shocking. Although men's body images have become more negative in recent years (Cash, Winstead, & Janda, 1986), it is clear that women have more disturbed body images than do men (Cash & Brown, 1989; Cash & Pruzinsky, 1990; McCreary & Sadava, 2001). In a 1993 national survey that assessed the body images of 803 women in the United States, Cash and Henry (1995) found that approximately one-half of the women reported body dissatisfaction and a preoccupation with being or becoming

overweight. In keeping with Cash and Henry's findings, large-scale surveys conducted in 1972 and 1996 show that body image disturbances have increased from 23 to 56 percent for women (e.g., Berscheid, Walster, & Bohrnstedt, 1973).

Mintz and Betz (1988) reported that 61 percent of college-aged women engaged in some form of disordered eating, such as fasting or purging; similarly, Tylka and Subich (2002) found that large percentages of high school and college-aged women and girls engaged in behaviors such as skipping meals, eating fewer than 1,200 calories a day, using laxatives and diuretics, and vomiting after eating. Researchers have in fact suggested that body image disturbances are so prevalent among women that they are normative (e.g., Mazzeo, 1999; Striegel-Moore, Silberstein, & Rodin, 1986; Tylka & Subich, 2002), and negative body image has been dubbed a "normative discontent" (Rodin, Silberstein, & Striegel-Moore, 1984).

Research has shown certain exceptions to the normative discontent described above. For example, Cash and Henry (1995) found that African American women reported significantly more positive body images than European American or Hispanic women. Differences in body image disturbance also occur across the life span, with more negative body image associated with the adolescent years (Cash, Winstead, & Janda, 1986). Little research has been done on differences in body image between lesbian and heterosexual women. Despite these differences, it is clear that many women of all races, ethnicities, sexual orientations, and ages have body image disturbances and that these disturbances are associated with increased distress and psychopathology.

The prevalence of body image disturbance among women makes it reasonable to conclude that many women clients may seek counseling for distress and psychopathology

associated with body image disturbance. Thus, it is crucial that counselors are effectively able to assist such clients. Women counselors are not immune from body image disturbance, however. Indeed, body image disturbance is so prevalent that it also seems reasonable to conclude that many women counselors will have unresolved issues around body image. Clients presenting with distress associated with body image disturbance may elicit particular reactions in counselors similarly suffering from body image disturbance. As will be discussed below, these reactions may be seen as countertransference reactions, and, if unmanaged, this countertransference may interfere with a counselor's ability to help her client.

Social Comparison and Body Image

Sociocultural factors and social comparison may explain the etiology of body image disturbances (e.g., Botta, 2003; Carlson Jones, 2001; Evans, Gilpin, Farkas, Shenassa, & Pierce, 1995; Garner, Garfinkel, Schwartz, & Thompson, 1980; Heinberg & Thompson, 1991; Heinberg & Thompson, 1992a, 1992b; Jacobi & Cash, 1994; Polivy & Herman, 1985; Stice, Schupak-Neuberg, Shaw, & Stein, 1994; Striegel-Moore, Silberstein, & Rodin, 1986; Wood, 1989). First proposed by Festinger (1954), social comparison theory states that people make judgments about their own attributes compared to others. Comparisons in which people judge themselves to be superior on the given attribute result in increased self-esteem and positive affect, whereas comparisons that result in a negative self-evaluation lead to decreased self-esteem and increased negative affect. Comparisons to others who are superior on the attribute in question are called upward comparisons; comparisons to others who are inferior are called downward comparisons. If one were to make an upward comparison on the attribute of body size

and/or shape, this comparison would theoretically result in decreased self-esteem, increased negative affect, and, presumably, a more negative body image. By extension, the more upward comparisons one makes concerning body size and/or shape, the more negative one's body image.

The current sociocultural climate encourages such upward comparisons. In a classic study, Garner, Garfinkel, Schwartz, and Thompson (1980) examined the changes in weights of *Playboy* centerfold models and Miss America Pageant contestants from 1959 to 1978. They found a decrease in the weights of centerfold models and pageant contestants over these years. In contrast, weights of women ages 17 to 24 in the general population increased. Additionally, Garner and his colleagues found that the bust and hip measurements of *Playboy* centerfold models decreased over time, yet the models' heights increased, indicating a thinner, more streamlined standard of beauty. Trends have similarly shown a decrease in the weight of fashion models (Morries, Cooper, & Cooper, 1989) and actresses (Silverstein, Perdue, Peterson, & Kelly, 1986).

Not only is the standard of beauty more stringent, but also, women are increasingly encouraged to conform to it. Garner and his colleagues (1980) also examined the content of six popular women's magazines (*Harper's Bazaar*, *Vogue*, *McCalls*, *Good Housekeeping*, *Ladies Home Journal*, and *Woman's Day*) from 1959 to 1978 and found a significant increase in the number of articles devoted to diet. Anderson and DiDomenico (1992) and Nemeroff, Stein, Diehl, and Smilack (1994) have shown that compared to men's magazines, women's magazines much more frequently contain articles and advertisements devoted to diet, health, fitness, and beauty. While American women have been getting larger, the standards of beauty portrayed in the media have

been getting thinner; there is also more pressure in today's society to conform to this thinner standard.

Exposure to the media ideal is theorized to affect body image disturbance via social comparison (e.g., Botta, 2003; Heinberg & Thompson, 1992; Posavac, Posavac, & Posavac, 1998). For most women, comparison to the media images with which they are bombarded is an upward comparison. Social comparison theory states that people prefer to compare themselves to those who they see as similar on a given attribute (Miller, Turnbull, & McFarland, 1988). However, as described above, women are increasingly bombarded by and encouraged to conform to the media ideal. Thus, comparison to media standards of beauty may be inescapable for many women. This constant upward comparison may lead to body image disturbance.

Many studies have examined the link between exposure to media images and increased body image disturbance in women. Posavac, Posavac, and Posavac (1998) performed a series of experiments in which women participants were exposed to slides of the media ideal of beauty. They found that after viewing slides of fashion models, women reported increased weight concern, as measured by the Weight Concern subscale of the Body Esteem Scale (Franzoi & Shields, 1984). However, this increased concern was moderated by the trait variable, body dissatisfaction, as measured by the Body Dissatisfaction subscale of the Eating Disorders Inventory (second edition; Garner, 1991). Women who initially reported greater dissatisfaction experienced an increased concern with weight, whereas women who were low on body dissatisfaction did not experience an increased concern with weight.

Posavac et al. (1998) posit a social comparison process to explain their results:

“Female perceivers assess their appearance relative to society’s standard as depicted in the media. Because the media’s perfected image of slim feminine attractiveness is so exaggerated, most of our participants were doomed to perceive a discrepancy between their bodies and that of the media standard when they compared their bodies with those of the fashion models” (p. 199).

As proposed by social comparison theory, this perceived discrepancy leads to a negative self-evaluation and increased negative affect. The authors further posit that the women who were initially assessed as satisfied with their bodies did not experience increased weight concern for one of two reasons. First, these women may have had low body dissatisfaction because their bodies are similar to those of the models. They therefore would not have perceived a discrepancy between their own and the model’s shapes. Second, body image issues may not be important for some women. The authors suggest that some women may derive their self-esteem from skills and abilities other than appearance. For these women, images of models are not a threat to the self-concept and thus do not increase concern with weight.

Botta (2003) looked at the relationship between adolescent boys’ and girls’ magazine reading and eating disturbances. Studies have found that magazine reading is related to women’s body image and eating disturbances (e.g., Harrison, 2000; Harrison & Cantor, 1997). Botta studied the explicit effect of social comparison on this relationship. She asked participants to answer questions about how often they notice models’ bodies in magazines and in what ways they compare their own bodies to those of models when

reading magazines. Although we cannot be certain of the direction of causality, she found that increased social comparisons were related to increased anorexic behaviors, bulimic behaviors, and drive to be thin and to decreased body satisfaction. Thus, girls who noticed models' bodies and compared themselves to models were more likely to experience body image and eating disturbances. Frighteningly, she found that magazine reading and processing accounted for 28.0% of the variance in girls' anorexic behaviors, 27.5% of the variance in girls' bulimic behaviors, 23.4% of the variance in girls' body satisfaction, and 41.6% of the variance in girls' drive to be thin.

Hausenblas, Janelle, Gardner, and Hagan (2002) assessed participants' in-task emotional responses, specifically pleasure and arousal, to viewing slides of either themselves or men and women representing the societal, ideal standard. They found that women high on body dissatisfaction reported decreased pleasure when viewing both the self and ideal slides. As with the previously described studies, these authors suggest that social comparison is responsible for these effects. When viewing slides of themselves, women high on body dissatisfaction may have perceived a discrepancy between their picture and their internalized ideal, thus decreasing their positive affect. Similarly, when viewing slides of women representing the ideal, they may have perceived a discrepancy between the ideal slide and their internalized view of self, again decreasing their positive affect.

It is especially important to note that unlike the other studies described above, the ideal slides in this study were not pictures of fashion models, but rather pictures of college students whose Body Mass Index (BMI) and body fat percentage represented the ideal. Body Mass Index is a ratio of a person's weight to height squared. People whose

BMIs are less than 18.5 are considered underweight; people whose BMIs are between 18.5 and 24.9 are considered normal weight; people whose BMIs are between 25.0 and 29.9 are considered overweight; and people whose BMIs are greater than 30.0 are considered obese. The recommended body fat percentage for women is between 20 and 30 percent. In Hausenblas et al.'s study, the woman representing the ideal had a BMI of 19.75. (It is important to note that at the time of this study, the healthy BMI range was considered between 20.0 and 25.0, not 18.5 and 24.9.) Her body fat percentage was 16.7 percent, which is below normal but consistent with the ideal presented in the media. Jones (2001) similarly found that adolescents compare themselves to peers on several dimensions of physical attractiveness, including weight and body shape, and that these comparisons often result in increases in body dissatisfaction.

Based on this and the previously described studies, one can conclude that women with body image disturbance experience decreased positive and increased negative affect through the process of social comparison. This decrease in positive and increase in negative affect occur when women are confronted not only with pictures of fashion models, but also with pictures of everyday women whose physiques are similar to the ideal. A counselor with body image disturbance may similarly experience a decrease in positive and increase in negative affect when with a client whose physique is similar to the ideal. What is more, this effect may be heightened if the client is explicitly discussing body image concerns. As will be discussed below, this change in affect is an internal countertransference reaction. Counselors may act on these internal reactions. Indeed, Dworkin and Kerr (1987) argue that counselors too often reinforce dieting and body image disturbance instead of challenging the societal ideal. It is reasonable to suppose

that counselors reinforce rather than change a client's body image disturbance at least partly because of their own unresolved issues around body image. This acting out of counselor unresolved issues in the session is an example of a behavioral countertransference reaction, as will be described below.

Thus far I have explored how the construct of body image has been variously defined by researchers. Body image disturbance is so prevalent in today's society that it is called a "normative discontent," and body image disturbance has serious consequences for women's mental health. Social comparison has been proposed as the primary mechanism by which body image disturbance occurs. I will now turn my attention to countertransference, in particular the historical development of the construct and Hayes's (1995) five-factor model of countertransference. I will integrate what I have reviewed about body image throughout the following section as it relates to countertransference.

Countertransference

Definition of Countertransference

Sigmund Freud (1910, 1959) first introduced the concept of countertransference. Freud's writings about countertransference exhibit much ambivalence, and this ambivalence continues to the present day. On the one hand, Freud viewed introspection on the analyst's part into his or her own unconscious motives as helpful to the analysis:

"He must bend his own unconscious like a receptive organ towards the emerging unconscious of the patient... so is the physician's unconscious mind able to reconstruct the patient's unconscious..." (Freud, 1912, p. 328).

In other words, by attending to the analyst's own unconscious, he or she may better understand the patient's unconscious. Understanding of the patient's unconscious is the ultimate goal of psychoanalysis; thus, according to this view, the analyst's unconscious is central to the very goal of therapy.

However, Freud made other, contradictory statements about countertransference that portrayed it as completely antithetical to successful analysis:

“We have begun to consider the ‘counter-transference’, which arises in the physician as a result of the patient’s influence on his unconscious feelings, and have nearly come to the point of requiring the physician to recognize and overcome the counter-transference in himself” (Freud, 1910, p. 289).

According to Freud, countertransference is to be avoided at all costs, and no use can be made of it in the analysis. These contradictory positions on countertransference are reflected in the various positions on countertransference espoused over the years by theorists. Four major historical views of countertransference are discussed below as well as the view of countertransference that informs the present work.

Classical Definition. Freud first proposed the classical view of countertransference, and later theorists expounded on this view (Reich, 1951; Stern, 1924). These theorists saw countertransference as the therapist's transference to the client's transference. The therapist's reactions are seen as largely unconscious, and they stem from the therapist's unresolved conflicts originating in early childhood. The client's transference triggers these unresolved issues in the therapist, who may then act these

conflicts out in a variety of ways (Gelso & Hayes, 2002). Gelso and Carter (1985, 1994) have termed this view of countertransference the classical definition. In this view of countertransference, the therapist acts out his or her own unresolved conflicts with the client, and this acting out is likely to be antitherapeutic. Thus, according to the classical view, countertransference is most often detrimental to the therapy. Working from this definition of countertransference, it is no wonder that Freud “required” physicians to rid themselves of it.

Totalistic Definition. In the 1950s, theorists such as Heimann (1950) and Little (1951) advocating what Gelso and Carter (1985, 1994) have termed the totalistic definition of countertransference challenged the classical definition of countertransference. Theorists promoting the totalistic view see all of the therapist’s reactions to the client as countertransference (Epstein & Feiner, 1988). It is useful to contrast this definition with the classical definition of countertransference. First, therapist reactions may be to any and all parts of the client’s material, not only the client’s transference. According to the totalistic view, therapist reactions to the client’s transference are still seen as countertransference. However, a therapist reacting, for example, to the content of the client’s story is also experiencing countertransference.

Second, therapist reactions are not limited to transference reactions. As with the classical view, the totalistic view allows that therapist reactions constituting countertransference may stem from unresolved conflicts originating in early childhood. However, therapist reactions not based in early childhood conflicts are also seen as countertransference. For example, a therapist experiencing a deeply saddened reaction to a client’s story of childhood abuse is not necessarily reacting out of his or her own

experiences with abuse. It is appropriate for the therapist to feel saddened by the client's deeply moving story; theorists supporting the totalistic view include such reactions in their definition of countertransference. Alternatively, certain clients may "pull" for certain reactions from others in all interpersonal relationships. A therapist reacting to the client in accordance with this pull is also experiencing countertransference according to the totalistic view, even though the therapist's reaction is more based in the client's personality and pathology than in the therapist's own dynamics.

Gelso and Hayes (in preparation) have pointed out that the totalistic view came to prominence at the same time as psychoanalytic therapists began to work with more severely disturbed clients. With a client suffering from borderline personality disorder, for example, it may be extremely difficult for the therapist to avoid all reactions for which the client pulls. Although these reactions, which often are quite intense, are not necessarily based in the therapist's unresolved issues, they are important to understand and make clinical use of. Thus, such "reality-based" reactions became included in the totalistic view. What is more, proponents of the totalistic view saw countertransference as useful clinical material. They did not see countertransference as theorists espousing the classical view saw it, namely a phenomenon to be avoided at all costs. Sullivan (1954), for example, believed that countertransference could be used beneficially if the therapist were aware of his or her reactions and then used them prudently in the work.

Kiesler (1982) divides countertransference as defined by the totalistic view into objective and subjective countertransference. Objective countertransference is defined as therapist reactions originating primarily from client dynamics. An example would be a therapist reacting to an exceedingly hostile client in a defensive or hostile way. Most

people interacting with the client would be expected to react in a similar manner.

Subjective countertransference is defined as therapist reactions originating primarily from therapist dynamics and includes the kind of “transference to the client’s transference” espoused by the classical view.

Gelso and Hayes (1998; in preparation) take issue with the totalistic view and Kiesler’s division of countertransference into objective and subjective pieces. In their view, the totalistic definition of countertransference is too broad:

“If all therapist reactions can be classified as countertransference, either subjective or objective, then the terms reaction and countertransference are redundant.... Of what additional utility is the term countertransference” (Gelso & Hayes, 1998, p. 84)?

Although all therapist reactions to a client may serve as important clinical data, in order to be a clinically and scientifically useful construct, countertransference may be best thought of as a particular subset of therapist reactions.

Complementary Definition. Epstein and Feiner (1988) describe another view of countertransference rooted in interpersonal theory. According to this complementary view, clients pull therapists to react in certain ways. In turn, therapists’ reactions to these pulls create reactions in the client. The client pulls for certain reactions from the therapist, and the therapist’s reactions to this pull may or may not be tied to the therapist’s own psychopathology.

Gelso and Hayes (in preparation) describe the relationship between the object relations school’s notion of projective identification and the complementary view of

countertransference. A client “projects” part of his or her psychic world onto the therapist, who then “identifies” with this part of the client’s psyche. The therapist’s identification with part of the client’s psyche can be seen as a response to a pull from the client, and it constitutes a countertransference reaction according to the complementary view. Gelso and Hayes criticize this view of countertransference for ignoring the therapist’s contributions to the countertransference and only highlighting the importance of how client dynamics elicit reactions from therapists. Therapists bring their own issues to the therapeutic encounter and are therefore complicit in the creation of countertransference.

Relational Definition. Gelso (2004) describes what he calls the relational view of countertransference. Relational theorists emphasize co-construction of the therapy relationship. More specifically, both the client and the therapist contribute to the countertransference. A given client’s dynamics may cause the client to pull for certain reactions from the therapist, but similarly, the therapist’s dynamics influence how he or she reacts to and what he or she pulls for from the client. Thus, unlike the complementary view, countertransference originates in the interplay between client and therapist dynamics and does not stem primarily from the client’s dynamics. Gelso and Hayes (in preparation) criticize the relational view, however, for failing to recognize how the individuals who make up the therapy relationship are constant over time and between relationships. Clients will act in similar ways with all therapists, and therapists will act in similar ways with all clients.

Integrative Definition. Gelso and Hayes (in preparation) propose an integrative definition of countertransference. They see countertransference as “the therapist’s

internal or external reactions that are shaped by the therapist's past or present emotional conflicts and vulnerabilities." Furthermore, these reactions can be used beneficially in therapy "if the therapist successfully understands his or her reactions and uses them to help understand the patient" (Gelso and Hayes, 2002, p. 269). This definition combines important aspects of the four definitions described above, yet rejects certain aspects of the previous definitions. For example, in accord with the classical definition, countertransference is seen as rooted in the therapist's unresolved conflicts. In contrast to the classical definition but in accord with the totalistic definition, this definition does not view countertransference as necessarily damaging to the therapeutic work. As with the complementary definition, the trigger for the countertransference reaction may lie outside the therapist in the covert or overt behaviors of the client. However, triggers for the countertransference reaction are not limited to client behaviors, and, no matter what the trigger, the reaction must implicate an unresolved therapist issue. Additionally, countertransference reactions as defined above may be internal or external. Examples of internal and external countertransference reactions are discussed below in the section describing countertransference manifestations.

Lastly, these unresolved therapist issues may reside in the past, as in the classical definition, or the present. Thus, for a therapist who is influenced in her current life by the media ideal of body shape, body image disturbance may constitute a present unresolved issue. According to Gelso and Hayes's definition of countertransference, the unresolved issue of body image disturbance may lead to countertransference reactions in therapists when client behaviors trigger this unresolved issue. One such client behavior could be the client presenting material related to body image disturbance. This content may trigger

countertransference reactions in therapists for whom body image disturbance is an unresolved issue. Another potential client trigger for a therapist countertransference reaction may be the client's physique. If the client's physique is close to the media ideal, therapists may experience a heightened countertransference reaction based on the social comparison process described above. Thus, the combination of session content and client physique may be a particularly potent trigger for countertransference reactions in therapists with unresolved body image issues.

In a qualitative study of eight therapy dyads, Hayes, McCracken, McClanahan, Hill, Harp, and Carozzoni (1998) found that countertransference reactions, when defined in this fifth, integrative way, are extremely common. Therapists identified countertransference in 80% of their sessions. It is important to note that this figure may underestimate the actual prevalence of countertransference. This figure is based on therapist self-report, thus it only captures conscious countertransference reactions, and unconscious reactions went undetected. What is more, the therapists in this study were considered by their peers to be expert. It is likely that among therapist trainees like the participants in the current study, countertransference may be even more prevalent.

Model of Countertransference

Hayes (1995) proposed a structural theory of countertransference based on the working, integrative definition given above. In this theory, countertransference is conceptualized as containing five structural elements: Origins, Triggers, Manifestations, Effects, and Management. Using these five structures, this theory explains where countertransference comes from (origins), what causes it in a therapy session (triggers), how it is acted out in the session (manifestations), what effect it has on therapy (effects),

and how therapists can manage it in the service of treatment (management). The present study examines three of these structural elements, origins, triggers, and manifestations, as they pertain to therapist countertransference to a client with body image disturbance.

Origins. As discussed above, countertransference originates in the therapists' unresolved issues and conflicts, either past or present. All therapists experience countertransference because all therapists are human and have some degree of unresolved issues. In the qualitative study mentioned above, Hayes et al. (1998) found four general categories of countertransference origins. First, they found that family issues stimulated countertransference reactions in all eight therapists. Therapists identified specific unresolved issues leading to countertransference in three subcategories of the general category of family issues: family of origin, parenting, and partnering. A second category of countertransference origins included therapists' needs and values, for example, the grandiose and narcissistic needs to be important, powerful, right, and gratified. Third, Hayes et al. identified origins relating to the role of the therapist itself. For example, some therapists had issues related to termination or to therapy performance. Lastly, cultural issues were also identified as countertransference origins. Gender and race were subcategories of the cultural issues category, and gender and race issues were triggered by cross-gender or cross-race dyads. For example, one of the male therapists in the study needed to be a "strong male" with his female clients, and he felt threatened when he perceived his female client as powerful.

Body image disturbance may be seen as a specific example of a gender/societal issue that may constitute a countertransference origin. As discussed above, body image disturbance is rooted in societal expectations about women's bodies. Body image

disturbance constitutes a normative discontent, thus many women therapists may be afflicted with it. For these women, same-gender dyads may be most threatening, particularly when the client is explicitly talking about her own body image issues. Gelso and Hayes (2002) state:

“Clinical experience suggests that it is the interaction of patient material with therapist unresolved conflicts that more powerfully stimulates [countertransference] reactions. In keeping with this conception, several empirical studies to date have supported an interaction hypothesis” (p. 272).

Thus, the interaction of therapist unresolved issue (i.e., body image disturbance) and client behavior (i.e., presenting with body image concerns) is most likely to lead to countertransference reactions.

Several studies have found that higher therapist anxiety, either state or trait, hinders the therapy process (Bandura, 1956; Yulis & Kiesler, 1968; Milliken & Kirchner, 1971; Gelso & Hayes, 1991). Therapists who are more anxious may avoid client affect, inaccurately recall session material, and ignore client’s feelings about the therapist. Anxiety may be indicative of underlying, unresolved therapist issues that are the origins of countertransference. Similarly, a measure of therapist body image disturbance may indicate which therapists are likely to have countertransference reactions to clients presenting with body image concerns.

Triggers. Countertransference reactions are triggered when events in therapy touch on therapist unresolved issues (origins). Examples of triggers include a client’s

discussion of a topic (e.g., a client talking about body image concerns) or client behaviors, such as being late for sessions or demanding more of the therapist's time. Previous research has focused on clients' presenting problems (e.g., Gelso, Fassinger, Gomez, & Latts, 1995; Harbin, 2004; Hayes & Gelso, 1993; Latts & Gelso, 1995) and clients' presenting style (e.g., Harbin, 2004; Hayes & Gelso, 1991; Peabody & Gelso, 1982; Robbins & Jolkovski, 1987; Yulis & Kiesler, 1968). Studies on clients' presenting style have focused on hostile, seductive, dependent, and angry client styles (Harbin, 2004; Hayes & Gelso, 1991; Peabody & Gelso, 1982; Robbins & Jolkovski, 1987; Yulis & Kiesler, 1968). Studies focusing on clients' presenting problems have included sexual assault, HIV infection, same-sex relationship problems, and race-related concerns (Gelso et al., 1995; Harbin, 2004; Hayes & Gelso, 1993; Latts & Gelso, 1995).

The overall conclusion based on these studies is that client factors alone tend not to trigger countertransference. Rather, it is the interaction between client presenting style and/or problem and therapist unresolved issues that most powerfully triggers countertransference. Looking at both theoretical and empirical literature, Rosenberger and Hayes (2002) concluded, "Client factors, in and of themselves, do not predictably cause countertransference reactions" (p. 221). However, several empirical studies have supported the effect of the client factor-therapist issue interaction on countertransference. Gelso, Fassinger, Gomez, and Latts (1995), for example, found that therapists had no more countertransference to a lesbian client than to a heterosexual female client. However, they did find that therapist homophobia interacted with client sexual orientation as predicted. Namely, therapists who were high on homophobia had more countertransference to a lesbian than to a heterosexual female client. Hayes and Gelso

(1993) found a similar interaction of homophobia with client sexual orientation for gay male clients.

The present study will examine the interaction between client presenting style/problem and the potentially unresolved therapist issue of body image disturbance. In terms of client presenting style, the clients will present with a body type that is either close to or far from the societal ideal. In terms of client presenting problem, the clients will present with body image disturbance. Rosenberger and Hayes (2002) suggest, “One of the ways in which client and therapist factors plausibly interact to evoke countertransference reactions is when the client discusses material related to the therapist’s unresolved issues” (p. 221). For therapists with body image disturbance, therefore, a client who presents with body image concerns may be especially likely to trigger therapist countertransference.

Manifestations. Manifestations are internal and external reactions that result from the triggering of the therapist’s unresolved issues. Internal reactions include affects, cognitions, images, or bodily sensations. External reactions include verbal and nonverbal behaviors. Research has shown that internal reactions often take the form of anxiety (Cohen, 1952; Gelso et al., 1995; Yulis & Kiesler, 1968) or cognitive distortion of client material, particularly inaccurate recall of the frequency with which clients used certain words (Cutler, 1958; Gelso et al., 1995; Harbin, 2004; Hayes & Gelso, 1993). External reactions often take the form of withdrawal from or avoidance of client material (Bandura, Lipsher, & Miller, 1960; Harbin, 2004; Hayes & Gelso, 1991, 1993; Latts & Gelso, 1995; Yulis & Kiesler, 1968) or overinvolvement with the client (Gelso et al., 1995). In keeping with previous research (Gelso et al., 1995; Harbin, 2004; Hayes &

Gelso, 1993; Latts & Gelso, 1995), the present study will examine therapist anxiety, cognitive recall of client material, and avoidance behavior.

Affective countertransference reactions in the form of state anxiety have been particularly studied. As described above, the presence of anxiety, either state or trait, often indicates the presence of underlying unresolved issues (Singer & Luborsky, 1977). Gelso and Hayes (1993) found that therapists had increased anxiety with an HIV-positive as opposed to an HIV-negative client. Sharkin and Gelso (1993) similarly found that anger-prone therapists had increased anxiety when a client was angry with them. By extension, therapists with body image disturbance may experience increased anxiety when presented with a client with body image concerns.

Many studies have examined inaccurate recall of client material as a measure of cognitive countertransference reactions. When client material touches on therapists' unresolved issues, therapists remember this material inaccurately (Cutler, 1958; Gelso et al., 1995). Cutler, who pioneered this technique, found that therapists either under- or over-report client material when clients talk about issues that are unresolved for the therapist. For example, Gelso et al. found that when lesbian clients talked about sexual problems, women therapists incorrectly recalled the number of sexual words the clients used. No incorrect recall was found for male therapists, and no incorrect recall was found for either male or female therapists with heterosexual women clients. It appears that when lesbian clients talk about sexual difficulties with women therapists, this material taps into unresolved issues around sexuality for those therapists.

Measuring cognitive recall of client material has the advantage of being free from social desirability. Well-trained therapists may not exhibit avoidance behaviors or report

increased anxiety when with clients who trigger their unresolved issues, especially if it is not “politically correct” to do so, as with a lesbian client. However, therapists have no way of knowing the objective frequency with which a client uses certain words or discusses certain topics, thus they are unable to alter their responses to the cognitive recall question in a socially desirable way.

The freedom of the cognitive recall measure from social desirability effects is important for the present study. Body image is a politically correct topic. Champions of women’s rights, including therapists, are expected to revolt against the societal ideal of beauty. Thus, therapists may be aware of their behavioral and affective reactions to a client with body image disturbance and may respond to the client in politically correct ways. However, their cognitive recall of client material related to body image will be unaffected by their desire to be politically correct.

Behavioral countertransference reactions have typically been studied as therapist avoidance of client material. Bandura, Lipsher, and Miller (1960) devised a coding system that divides therapist responses into approach and avoidance responses. Approach responses encourage further client exploration and include approval, exploration, reflection, and labeling. Avoidance responses inhibit, discourage, or divert further client exploration and include disapproval, ignoring, mislabeling, or topical transition. Gelso et al. (1995) found that therapists who were high on homophobia exhibited greater avoidance behavior in a session with a lesbian client than those who were low on homophobia. Hayes and Gelso (1993) found similar results with a gay male client. Studies that have attempted to operationalize behavioral countertransference as overinvolvement with client material have not been successful (Gelso et al., 1995). In the

present study, it is expected that therapists who suffer from body image disturbance will exhibit avoidance behaviors with clients with body image concerns.

Effects. Countertransference manifestations may affect the therapy process and outcome. As described in the above section on the classical definition of countertransference, theorists have traditionally supposed that countertransference always hinders therapy. Indeed, in a review of countertransference literature, Singer and Luborsky (1977) concluded, “uncontrolled countertransference has an adverse effect on therapy outcome” (p. 449). Ligiero and Gelso (2002) found negative countertransference to be related to poorer overall working alliances and positive countertransference to be related to a weak bond within the working alliance; Hayes et al. (1995) found countertransference behavior to be related to poor outcome.

Supporters of all but the classical approach, however, have maintained that when properly understood and managed, countertransference may promote the therapeutic process. Studies have supported this notion. Gelso et al. (2002) found that countertransference management abilities were positively related to therapy outcome. Management factors will be discussed further in the next section.

Management. Management factors are therapist factors that help therapists identify and use their countertransference reactions in the service of the therapy. By identifying countertransference reactions, particularly internal reactions, therapists may be less likely to act on these reactions in a session. In this way countertransference management can lead to a reduction in countertransference behavior. Beyond this reduction in harmful behavior, however, a therapist who identifies and understands his or her countertransference reactions may be able to use these reactions in the work. Hayes

(1995) suggests that being in therapy, using supervision, reflecting on sessions, and meeting one's needs outside of work are all behaviors that facilitate countertransference management.

VanWagoner, Gelso, Hayes, and Diemer (1991) identified five interrelated factors in the management of countertransference: self-insight, self-integration, empathy, anxiety management, and conceptualizing ability. Research has supported the relationship between these factors and the regulation of countertransference reactions (Friedman & Gelso, 2000; Hayes, Gelso, VanWagoner, & Diemer, 1991; Van Wagoner, Gelso, Hayes, and Diemer, 1991), working alliance, and positive therapy outcome (Rosenberger & Hayes, 2002; Gelso, Latts, Gomez, Fassinger, 2002). Regarding the definition of these factors, self-insight refers to the extent to which a therapist is aware of his or her feelings, including countertransference feelings, and understands their origin. Self-integration refers to a therapist's having an intact character structure and to his or her ability to understand the boundaries between himself or herself and the client. Empathy permits a therapist to focus on a client's needs despite whatever countertransference feelings he or she might be experiencing in a session. Therapists who are successful at managing their anxiety can identify and experience their anxiety without allowing it to spill out into their work with a client. Lastly, having good conceptualizing skills allows therapists to draw on their theoretical orientation to understand the client's dynamics and how they are affecting the therapy relationship.

A female therapist who has internalized societal standards of beauty may suffer from body image disturbance. What is more, the normative discontent of body image disturbance makes it likely that many women therapists have at least some degree of

body image disturbance. This body image disturbance constitutes an unresolved issue for the therapist. If a client presents with body image concerns, the session content may trigger countertransference reactions in the therapist. These reactions may be particularly salient depending on the client's presenting style, namely if her physique is close to or far from the societal ideal. Therapists' countertransference reactions may take the form of increased anxiety, inaccurate cognitive recall of client material relating to body image, and avoidance of client material related to body image. This study therefore examines the effects of therapist body image disturbance and client presenting style on women therapists' countertransference to a woman client presenting with body image concerns.

CHAPTER 3

STATEMENT OF THE PROBLEM

Body image, defined as perception of, affect toward, cognitions about, and behavior aimed at changing one's body, is extremely prevalent in today's society. Societal pressures to look a certain way are extreme, as exemplified by Garner, Garfinkel, Schwartz, and Thompson's (1980) studies examining the percentage of space in popular women's magazines devoted to diet and the weights of Miss America pageant winners and *Playboy* centerfolds between 1959 and 1978. Research has also shown that some of the variance in body image dissatisfaction experienced by women and teenage girls can be explained by the amount of exposure they have to magazines and television. It seems natural to extend these findings to the amount of exposure women have to popular culture in general, which for many women is inescapable. Social comparison is the proposed mechanism by which this increase in body image disturbance as a result of exposure to the media ideal takes place.

Researchers have termed this pervasive, culturally induced dissatisfaction with body image "normative discontent." Not only do women tend to be unhappy with their bodies, they are increasingly going to extreme measures to change their bodies. As many as 61 percent of college-aged women engage in the disordered eating behaviors required for a diagnosis of anorexia or bulimia nervosa. What is more, even women who do not meet the criteria for a diagnosable eating disorder suffer psychological distress as a result of poor body image in the form of low self-esteem, depression, and neuroticism (Tylka and Subich, 1999). Clearly, the pressure to be thin in today's society has serious consequences for mental and physical health.

It seems reasonable to conclude that women who are dissatisfied with their body image might seek counseling as a result of the associated psychological distress. Thus, it is imperative that counselors are able competently to help women with body image concerns. However, it is likely that many women counselors also have unresolved body image concerns as a result of the pervasive nature of body image dissatisfaction in society.

Countertransference is a danger to the ability of counselors to help clients. In the present study, countertransference is defined as the therapist's internal or external reactions that are shaped by the therapist's past or present emotional conflicts and vulnerabilities. Counselors who are able to detect and manage their countertransference are effective in counseling sessions. For counselors who are not able to manage their countertransference, however, the countertransference is often manifested in the session as counselor anxiety, cognitive distortions of client material, and countertransference behaviors such as topical transitions or punitive or dismissive counselor responses.² Unmanaged countertransference has a negative impact on therapy outcome (Singer & Luborsky, 1977).

The high likelihood of unresolved body image concerns in women counselors suggests that women counselors may well experience countertransference toward women clients with body image concerns. It is therefore important to investigate the relationship between counselor body image disturbance and countertransference. What is more, a

² Affective responses other than anxiety (i.e., decreased pleasure, sadness) may also be manifestations of countertransference. However, it is likely that a woman counselor's countertransference to a woman client with body image concerns will manifest as increased counselor anxiety. As her own unresolved issues around body image become more salient in the session, the counselor may feel threatened by her client, particularly if the client's physique is close to the societal ideal. This feeling of threat may lead to increased counselor anxiety.

further step is to investigate what kinds of women clients with body image concerns are likely to prompt countertransference reactions in women counselors. The frequency with which counseling psychologists are likely to encounter women clients with body image concerns makes it imperative to understand if and how countertransference occurs in women dyads in which the client presents with body image concerns.

Hypothesis 1: Counselor body image disturbance will be positively related to counselor countertransference during or immediately following an analogue session with a client presenting with body image concerns.

Hypothesis 1 will be divided into three subhypotheses reflecting the three operationalizations of countertransference:

Hypothesis 1a: Counselor body image disturbance will be positively related to counselor state anxiety immediately following an analogue session with a client presenting body image concerns.

Hypothesis 1b: Counselor body image disturbance will be positively related to counselor cognitive distortion immediately following an analogue session with a client presenting body image concerns.

Hypothesis 1c: Counselor body image disturbance will be positively related to counselor behavioral avoidance during an analogue session with a client presenting body image concerns.

Counselors may experience countertransference reactions when client material hits upon counselor unresolved issues or vulnerabilities in a session. In the case of a client presenting with body image disturbance, the session content will include material about body image. If the counselor has personal, unresolved concerns around body

image, it is likely that she will have a countertransference reaction. These reactions may either be internal or external. Internal reactions may include feelings, thoughts, images, or bodily sensations, and external reactions include both verbal and nonverbal behaviors. For example, if a counselor with body image concerns listens to a client talk about body image disturbance, she may experience increased anxiety, may begin to think about the fattening chocolate cake she ate the night before, or may begin to study her own physical appearance instead of making eye contact with the client. She might try to change the topic or incorrectly assume that, just like the counselor, the client dislikes certain parts of her body.

If, however, the counselor does not suffer from body image disturbance, then she is unlikely to experience countertransference because she has no unresolved issues or vulnerabilities around body image. Therefore, the more body image disturbance a counselor has, the more countertransference she is expected to have to a client with body image disturbance.

Hypothesis 2: Counselors will experience more countertransference during or immediately following an analogue session with an ideal-close client presenting with body image concerns than they will during or immediately following an analogue session with an ideal-far client presenting with body image concerns.

Hypothesis 2 will be divided into three subhypotheses reflecting the three operationalizations of countertransference:

Hypothesis 2a: Counselors will experience more state anxiety immediately following an analogue session with an ideal-close client presenting with body image

concerns than they will immediately following an analogue session with an ideal-far client presenting with body image concerns.

Hypothesis 2b: Counselors will experience more cognitive distortion immediately following an analogue session with an ideal-close client presenting with body image concerns than they will immediately following an analogue session with an ideal-far client presenting with body image concerns.

Hypothesis 2c: Counselors will exhibit greater behavioral avoidance during an analogue session with an ideal-close client presenting with body image concerns than they will during an analogue session with an ideal-far client presenting with body image concerns.

In a meta-analytic study, Feingold (1992) concluded that people perceive attractive people as being more intelligent, sociable, dominant, *mentally healthy*, moral, and socially skilled than unattractive people. What is more, these perceptions go on outside the realm of conscious awareness (Dion, Bersheid, & Walster, 1972). Thus, a counselor presented with an ideal-close client will likely infer that the client is more mentally healthy than if her physique were far from the societal ideal. Meta-analysis also shows that attractive people are not superior to unattractive people in any of the categories listed above except social skills (Feingold, 1992). Thus, an ideal-close client presenting with body image concerns is no more mentally healthy than an ideal-far client with the same concerns. A counselor's belief that an ideal-close client's body image concerns are not as severe as those of an ideal-far client is a countertransference reaction. Counselors may act on these reactions in the session with an ideal-close client. For

example, they may be dismissive of the ideal-close client. Therefore, the counselor is likely to have more countertransference to the ideal-close than to the ideal-far client.

Hypothesis 3: The effect of client's body type (ideal-close or ideal-far) on counselor countertransference during or immediately following an analogue session with a client with body image concerns is moderated by counselor body image disturbance such that when counselor body image disturbance is low, there is little difference in counselor countertransference during or immediately following an analogue session with an ideal-close versus an ideal-far client, whereas when counselor body image disturbance is high, there is significantly more counselor countertransference during or immediately following an analogue session with an ideal-close client than with an ideal-far client.

Hypothesis 3 will be divided into three subhypotheses reflecting the three operationalizations of countertransference:

Hypothesis 3a: The effect of client's body type (ideal-close or ideal-far) on counselor state anxiety following an analogue session with a client with body image concerns is moderated by counselor body image disturbance such that when counselor body image disturbance is low, there is little difference in counselor state anxiety immediately following an analogue session with an ideal-close versus an ideal-far client, whereas when counselor body image disturbance is high, there is significantly more counselor state anxiety immediately following an analogue session with an ideal-close client than with an ideal-far client.

Hypothesis 3b: The effect of client's body type (ideal-close or ideal-far) on counselor cognitive distortion immediately following an analogue session with a client with body image concerns is moderated by counselor body image disturbance such that

when counselor body image disturbance is low, there is little difference in counselor cognitive distortion immediately following an analogue session with an ideal-close versus an ideal-far client, whereas when counselor body image disturbance is high, there is significantly more counselor cognitive distortion immediately following an analogue session with an ideal-close client than with an ideal-far client.

Hypothesis 3c: The effect of client's body type (ideal-close or ideal-far) on counselor behavioral avoidance during an analogue session with a client with body image concerns is moderated by counselor body image disturbance such that when counselor body image disturbance is low, there is little difference in counselor behavioral avoidance during an analogue session with an ideal-close versus an ideal-far client, whereas when counselor body image disturbance is high, there is significantly more counselor behavioral avoidance during an analogue session with an ideal-close client than with an ideal-far client.

Social comparison theory indicates that people who are sensitive to body image issues determine their own attractiveness by comparing themselves to others. Thus, a counselor with body image concerns may compare herself to her client. If the client is ideal-close, the counselor may evaluate herself negatively, and her own body image concerns may become particularly salient during the session. This social comparison process therefore leads to increased countertransference. However, when the client's physique is ideal-far, the counselor's comparison of herself to the client is less likely to result in a negative self-evaluation, and the counselor's body image concerns will not become more salient. Thus, with an ideal-far client, there is less reason for a counselor with body image disturbance to experience countertransference.

A counselor who does not suffer from body image disturbance, on the other hand, is less likely to have differential countertransference reactions to an ideal-close versus an ideal-far client. Women may not suffer from body image disturbance for one of two reasons (Posavac, Posavac, & Posavac, 1998). First, their own physique may be close to the ideal, and the social comparison process may therefore not result in a negative self-evaluation. Alternatively, they may not derive their self-esteem from their body's appearance, and they would therefore be unlikely to go through a social comparison process related to their bodies.

Counselors who do not suffer from body image disturbance because their physique is ideal-close may go through a social comparison process with their clients. However, this process will not result in a negative self-evaluation with either an ideal-close or an ideal-far client. For these counselors, there will be no difference in countertransference to ideal-close or ideal-far clients. Counselors who do not suffer from body image disturbance because they do not derive their self-esteem from their body's appearance will not go through the social comparison process at all. Thus, there will be no difference in countertransference to ideal-close or ideal-far clients for these counselors, either.

A counselor who does not suffer from body image disturbance will not experience as much countertransference to an ideal-close client as will a counselor with body image disturbance. This dampening of the difference in countertransference reactions to ideal-close versus ideal-far clients as a result of counselor body image disturbance indicates that, as hypothesized above, counselor body image disturbance has a moderating effect on the relationship between client body type and counselor countertransference.

CHAPTER 4

METHOD

Research Design

The present study is an audio-visual analogue (Gelso & Fretz, 2001). Counselor participants' body image disturbance was assessed via questionnaire prior to the analogue session. Counselors then watched and interacted with a video of either an ideal-close or ideal-far client presenting body image concerns. An ideal-close client is a client whose body type is similar to the societal ideal, and an ideal-far client is a client whose body type is dissimilar to the societal ideal. There were two predictor variables, one continuous and one categorical. Body image disturbance was the continuous predictor variable, and client body type was the categorical predictor variable and was manipulated. The dependent variables were affective, cognitive, and behavioral countertransference reactions. Counselors completed measures of affective and cognitive countertransference immediately after the analogue session, and three judges rated counselors' audiotaped responses to the client to determine degree of behavioral countertransference.

Participants

Based on numbers of participants in previous, similar studies and a power calculation ($1 - \beta = .80$) in which a large effect size was estimated, there were 35 participants in the present study (Harbin, 2004; Kirk, 1995). Participants were female graduate students in the counseling psychology Ph.D. program ($n = 13$), the clinical psychology Ph.D. program ($n = 9$), the school psychology Ph.D. program ($n = 2$), the social work M.A. program ($n = 2$), the rehabilitation counseling M.A. program ($n = 3$), and the college student personnel M.A. program ($n = 6$) at the University of Maryland.

They had all completed at least one pre-practicum course or were enrolled in a practicum course at the time of participation. Regarding race and ethnicity, 22 participants identified as European-American (White), 4 identified as Asian-American, 2 identified as African-American, 2 identified as Latina, and 5 identified as other. Regarding sexual orientation, 28 participants identified as heterosexual, 6 identified as bisexual, and 1 identified as lesbian. Participants also rated the degree to which they adhered to the techniques of three theoretical orientations on separate 5-point Likert scales, where 5 = *very high belief*: psychoanalytic/psychodynamic ($M = 2.44$, $SD = 1.33$), experiential/humanistic/existential ($M = 3.62$, $SD = 1.04$), and behavioral/cognitive behavioral ($M = 3.37$, $SD = 1.24$). Lastly, the mean number of client hours in the sample was 204.12 ($SD = 306.13$). More demographic information about the sample is presented in Appendix M Tables 1 and 2 (pages 124 and 125).

Stimulus Tapes

Participants saw two videotaped clients. The first client was a warm-up client to prepare the participants for the analogue study format, get baseline state anxiety level data, and mask the true purpose of the study to participants. The first client was a female college student presenting with mild depression following her boyfriend breaking up with her (for the script, see Appendix B, page 101). The researcher worked with a team of eight undergraduate women recruited from upper-level psychology classes at the University of Maryland to refine this script. Through discussion and consensus, the language used in the script was made as close as possible to language used by actual undergraduate women. The videotape of the first client was approximately five minutes long and had five stopping points during which the participant verbally responded to the

client. This client was played by one of the actresses playing the stimulus client (see next paragraph). However, the actress playing the warm-up client was a different actress from the actress playing the stimulus client for each participant.

The stimulus client was played by one of four actresses. There were two actresses in the ideal-close client condition and two actresses in the ideal-far client condition. There were two actresses in each condition to control for possible, unwanted actress effects. The stimulus client script was the same in both the ideal-close and ideal-far client conditions. The stimulus client presented with body image concerns following an embarrassing incident with her boyfriend (for the script, see Appendix D, page 105). As before, the researcher worked with the same team of undergraduate women to refine the language used in this script so that it was as close as possible to language used by actual undergraduate women. Each member of the undergraduate team was paid ten dollars for her assistance in refining the two scripts. There were seven stopping points in the stimulus video during which participants verbally responded to the client, and the video lasted approximately seven minutes. In order to elicit the strongest countertransference reactions from counselors, the client viciously disparaged herself (e.g., called herself a “fat disgusting pig”) and described several scenarios expected to be familiar to the counselors in which body image is particularly salient (e.g., dining out, shopping for clothes).

In addition to physical attractiveness considerations (see Measures section below for a discussion of how actresses were selected for weight and attractiveness), actresses were rated on their believability and likeability. Ratings were made by six masters-level graduate students in counseling psychology on 5-point Likert scales, where 1 = *not at all*,

2 = *a little*, 3 = *moderately*, 4 = *much*, and 5 = *extremely*. For tapes to be usable, it was determined that ratings should be 3.0 or above on believability and exhibit no more than a 2.0 difference between the four actresses on believability and likeability. The means and standard deviations for each actress on believability and likeability are presented in Appendix N Table 1 (page 126). All four actresses met these criteria. What is more, there was no significant difference found between client physique conditions for believability ($t = -.81$, $p = .08$) or likeability ($t = -.80$, $p = .44$). Thus, actresses in one client physique condition were no more believable or likeable than actresses in the other client physique condition.

The videos were arranged so that the clients faced the viewer and talked directly to her. To make the analogue situation as realistic as possible, the videos were filmed in the same room in which participants watched the videos. Before viewing each video (warm-up and stimulus), participants read a two-paragraph summary of the client's family, personal, and social background. (For the case summaries, see Appendices A and C, pages 100 and 103.) The purpose of this summary was to familiarize participants with the client and to make the pretense that counselors have worked with the clients for four previous sessions more believable. The summary was identical in all stimulus conditions.

Measures

Eating Disorders Inventory-3 Body Dissatisfaction subscale (EDI-3 BD subscale: Garner, 2004). The EDI-3 is "a revision of the most widely used self-report measure [the EDI-2] of psychological traits or constructs shown to be clinically relevant in individuals with eating disorders" (Garner, 2004, p. 1). The EDI-3 is primarily used for case conceptualization and treatment planning with individuals who have or are suspected of

having an eating disorder. It is intended for use with older adolescent and adult females. It has nine subscales that are relevant to, but not specific to, eating disorders. Among these subscales is the Body Dissatisfaction (BD) subscale.³

The BD subscale consists of 10 items and assesses unhappiness with overall body shape and with areas of the body that are of extreme concern to women with eating disorders.⁴ The items tap into primarily affective and cognitive, and also perceptual, dimensions of body image. The internal consistency reliability of the EDI-3 BD subscale in both clinical and normative samples has been found to be good (i.e., $\alpha = .91$ and $\alpha = .92$ in two adult U.S. clinical samples; Garner, 2004). The test-retest reliability of the BD subscale of the EDI-3 over periods from one to seven days in a sample of women previously treated for eating disorders has also been found to be good (i.e., $r = .95$ in an adult U.S. sample; Garner).

The BD subscale of the EDI-3 is similar to the EDI-2 BD subscale except that one item has been added from the Interoceptive Awareness subscale of the EDI-2. This item was added to the BD subscale because it fit conceptually with the scale and had a moderate item-total correlation with the BD subscale. The correlation between the EDI-2 BD subscale and the EDI-3 BD subscale has been found to be .96 (Garner, 2004). The following discussion centers on use of the EDI-2 BD subscale in body image research because the EDI-3 has just recently been published. There are therefore no studies using the EDI-3 BD subscale in the literature.

³ The BD subscale of the EDI-3 cannot be reproduced in this thesis for copyright reasons. The interested reader can obtain the EDI-3 from Psychological Assessment Resources, Inc.

⁴ Although the areas of the body specified in the EDI-3 BD subscale are of extraordinary concern to women with eating disorders, they also seem to be areas of concern to women in general.

Researchers have found hypothesized relationships using the BD subscale of the EDI-2 as a measure of body image disturbance. For example, Posavac, Posavac, and Posavac (1998) found subjects' scores on the BD scale to be related to concern with weight after viewing slides of fashion models. Cusumano and Thompson (1997) found scores on the BD scale to be related to awareness and internalization of social norms of appearance, eating disturbances, and self-esteem. Botta (2003) found scores on the BD scale to be related to the amount of time teenage girls spent reading health/fitness magazines. These and other studies support the construct validity of the BD subscale of the EDI-2 (and by extension, the BD subscale of the EDI-3) as a measure of body image disturbance.

Client Body Type. Client body type was manipulated, and counselors were assigned to one of four client actresses representing two body types. Two actresses were ideal-close, and two were ideal-far. As described above, ideal-close actresses are actresses whose physiques are close to the societal ideal, though within the normal range, and ideal-far actresses are actresses whose physiques are far from the societal ideal, though within the normal range. There were two actresses in each body type condition to control for potential actress effects.

Following Hausenblas, Janelle, Gardner, and Hagan (2002), the societal ideal was operationalized as a Body Mass Index (BMI) on the low end of normal. BMI is a weight to height-squared ratio commonly used (e.g., by the Centers for Disease Control and Prevention) to determine if someone is underweight, normal weight, overweight, or obese for his or her height. A person with a BMI of less than 18.5 is considered underweight; a person with a BMI between 18.5 and 24.9 is considered normal weight; a person with a

BMI between 25.0 and 29.9 is considered overweight; and a person with a BMI over 30.0 is considered obese.

Some popular models and actresses who represent the societal ideal have BMIs less than 18.5 and are therefore underweight and unhealthy. However, operationalizing an ideal-close client as having a BMI less than 18.5 would have confounded body type with health. Thus, the researcher decided that actresses in the present study representing the ideal-close client should have BMIs of at least 18.5 but no more than 19.5. Specifically, both of the ideal-close actresses had a BMI of 19.2. The first actress weighed approximately 123 pounds and was five feet seven inches tall; the second actress weighed approximately 117 pounds and was five feet five and a half inches tall. It is unlikely that participants were able to detect the six-pound difference between these women. Even if they did detect the difference, however, there was still a clearly noticeable difference between the two levels of the independent variable (ideal-close and ideal-far).

The researcher decided that actresses whose BMIs were between 24.0 and 24.9 would play the role of the ideal-far client. A BMI up to 24.9 is considered normal weight. Thus, a client whose BMI is between 24.0 and 24.9 is healthy but clearly does not conform to the societal ideal. Once again, actresses whose BMIs were greater than 24.9 were not chosen so as not to confound body type with health. Specifically, one of the ideal-far actresses had a BMI of 24.8, and the other ideal-far actress had a BMI of 24.1. The first actress weighed approximately 168 pounds and was five feet nine inches tall; the second actress weighed approximately 154 pounds and was five feet seven inches tall. In this condition, the weight difference between the two actresses was 14 pounds. Although participants may have been able to detect this weight difference, there was still

a clear difference between the two levels of the independent variable (ideal-close and ideal-far).

The same team of six masters-level women graduate students in counseling psychology who rated the actresses' believability and likeability rated the actresses' BMI after watching each video. They were asked to rate each actresses' physique on 7-point Likert scale, where 1 = *normal/light*, *BMI=18.5*, 4 = *normal/moderate*, *BMI=21.7*, and 7 = *normal/heavy*, *BMI=24.9*. They were provided with a definition of BMI and urged not to respond in a politically correct way (e.g., rating a heavier actress as lighter than they believed she was so as not to imply that the actress was "fat") when making these ratings. A t test of the mean BMI differences between the ideal-close and ideal-far conditions was significant (ideal-close $\underline{M} = 1.83$, $\underline{SD} = .58$; ideal-far $\underline{M} = 5.67$, $\underline{SD} = 1.07$; $t = 10.90$, $p < .001$). t tests were also performed of mean BMI differences between actresses within each condition. No significant difference in BMI was found between actresses in the ideal-close condition (ideal-close 1 $\underline{M} = 2.17$, $\underline{SD} = .41$; ideal-close 2 $\underline{M} = 1.50$, $\underline{SD} = .55$); however, a significant difference in BMI was found between the two actresses in the ideal-far condition (ideal-far 1 $\underline{M} = 6.5$, $\underline{SD} = .55$; ideal-far 2 $\underline{M} = 4.83$, $\underline{SD} = .75$; $t = 5.00$, $p < .001$). As mentioned above, though, the weight difference of 31 pounds between the heaviest ideal-close actress and the lightest ideal-far actress was expected to outweigh the 14-pound difference between the two ideal-far actresses. Participants filled out this same measure of BMI as a manipulation check after watching the stimulus video. This manipulation check measure is presented in Appendix J (page 120), and the results of this manipulation check are discussed in Chapter 5.

Client facial attractiveness was held constant across the ideal-close and ideal-far conditions so as not to confound body type with facial attractiveness. For example, if the ideal-close client had a beautiful face and the ideal-far client had a homely face, there would have been no way to tease out reactions to the clients' body types from reactions to the clients' faces. Facial attractiveness was assessed in the standard way (e.g., Walster, Aronson, Abrahams, & Rottman, 1966). After watching each video, the same judges who rated believability, likeability, and BMI rated the actresses' physical attractiveness on a 5-point Likert scale, where 1 = *very unattractive* and 5 = *very attractive*. Judges were then instructed to rate each actress's physical attractiveness regardless of her weight, again on a 5-point Likert scale, where 1 = *very unattractive* and 5 = *very attractive*. The judges were asked to disregard weight in their second rating to ensure that facial attractiveness was not confounded with weight. The judges' ratings are discussed in the next paragraph.

Potential actresses were eliminated on two grounds. First, the researcher decided that potential actresses whose body type was unusual in some way would not be included. Potential actresses with extremely boyish, voluptuous, or athletic figures were excluded so as not to confound a specific body type with attractiveness. However, within the ideal-close condition, the first actress was somewhat taller and more curvy than the second actress, who had a more athletic and slender build. Within the ideal-far condition, the first actress was tall and curvaceous, whereas the second actress was shorter and had a more athletic and husky build. Second, potential actresses were eliminated if their average attractiveness ratings disregarding weight were not between three and five on the five-point scale described above. Descriptive statistics for attractiveness ratings both

regarding and disregarding weight are reported in Appendix N Table 2 (page 127). All four actresses met the above criterion. What is more, there were no significant differences in attractiveness and attractiveness disregarding weight between ideal-close and ideal-far client physique conditions.

Countertransference Assessment. A counselor's countertransference to a client can be thought of as including affective, cognitive, and behavioral reactions to client material (e.g., Gelso et al., 1995; Hayes & Gelso, 1993). Affective countertransference can take the form of increased state-anxiety (e.g., Gelso et al., 1995; Hayes & Gelso, 1991, 1993; Sharkin & Gelso, 1993); cognitive countertransference is manifested as distortion (i.e., incorrect recall) of client material (e.g., Cutler et al., 1958; Gelso et al., 1995; Hayes & Gelso, 1993); and behavioral countertransference includes avoidance of or withdrawal from client material (e.g., Bandura, Lipsher, & Miller, 1960; Hayes & Gelso, 1993). Affective, cognitive, and behavioral countertransference reactions were assessed in the present study.

Affective assessment. Therapist state anxiety was assessed immediately following the analogue session. Therapists experiencing countertransference were expected to have greater anxiety in the session than those who were not experiencing countertransference. State anxiety was measured using the State Anxiety Inventory (SAI; Spielberger, Gorsuch, Lushene, 1970), and therapists were asked to rate the measure as if they were still in the session with the client. The SAI has 20 items, rated on a scale from one (not at all) to four (very much so), that ask about anxious feelings. As explained below, therapists filled out this measure after seeing the warm-up and after seeing the

stimulus client. Both versions of the SAI (warm-up and stimulus) are presented in Appendix E (pages 108 and 109).

Many studies have found the SAI to have high internal consistency, for example $\alpha = .91$ (Gelso et al., 1995; Sharkin & Gelso, 1993). Studies have also found hypothesized effects using this measure of state anxiety, thus supporting the validity of the measure (e.g., Hayes & Gelso, 1991, 1993; Sharkin & Gelso, 1993). What is more, the measure has been found to have low test-retest correlation, for example ranging from .16 to .54, as would be expected with a state measure (Dreger, 1978).

State anxiety was measured as scores on the SAI after viewing the stimulus client (the client presenting with body image concerns). Scores on the SAI after viewing the warm-up client were controlled for in the analyses in order to separate out trait anxiety and/or state anxiety that is not directly related to viewing the tape of the stimulus client. Internal consistency for both the warm-up and stimulus SAI was high and in agreement with previous studies ($\alpha = .91$ and $\alpha = .92$ respectively; Gelso et al., 1995; Sharkin & Gelso, 1993). The specific analytic procedure is described in Chapter 5.

Cognitive assessment. After seeing the stimulus client, counselors were asked to remember the number of words relating to body, weight, or appearance the client used. (After seeing the warm-up client, counselors were asked to remember the number of words related to specific sadness the warm-up client used. This warm-up measure was not used in any analyses; its purpose was to mask the purpose of the study to participants by having participants fill out analogous measures after seeing each client. Both the warm-up and stimulus versions of this measure are presented in Appendix F, page 110.) Previous analogue studies have asked participants to report the number of words related

to a particular topic area the client used in the session as a measure of cognitive distortion of client material (Gelso et al., 1995; Harbin, 2004; Hayes & Gelso, 1993). It is assumed that the more distorted the participant's response, i.e., the further the participant's number is from the objective number of topic words, the more countertransference the participant experienced in the session. This assumption is based on Cutler's (1958) work indicating that therapists over-recall or under-recall client material that touches on their unresolved issues.

For example, Gelso et al. (1995) asked participants to report the number of sexual words a client used. They found a significant gender by sexual orientation interaction effect such that women therapists incorrectly recalled the number of sexual words used by a lesbian client but did not incorrectly recall the number of words used by a heterosexual female client. Men therapists did not incorrectly recall either lesbian or heterosexual female client material. The interpretation of these findings is that when lesbian clients talk about sexual difficulties with women therapists, this material taps into unresolved issues around sexuality for those therapists. Gelso et al.'s study supports the construct validity of the cognitive measure of countertransference because the hypothesized effects for cognitive countertransference were found.

A team of five raters (three graduate students in counseling psychology, one counseling psychology professor, and one advanced undergraduate student majoring in psychology) determined the objective number of words relating to body, weight, or appearance in the stimulus script. They counted the number of words in two ways. First, they counted phrases such as "gross fatso" as one word chunk. Second, they counted phrases such as "gross fatso" as two individual words. The words were counted in these

two ways to account for the fact that some participants might recall expressions like “gross fatso” as two separate words, whereas other participants might recall such expressions as multiple words. The raters then came to a consensus about which chunks and single words should be considered words relating to body, weight, or appearance.

There were a total of 33 word chunks and 38 single words relating to body, weight, or appearance in the stimulus script. The absolute value of the difference between the number of words participants recalled and the objective number of words was calculated for both word chunks and single words. The absolute value of the difference was used because countertransference is theorized to manifest itself as both over- and under-recall of client material (Cutler, 1958). The higher the absolute value of the difference, the more countertransference the participant was experiencing. These deviation scores constitute scores on this cognitive recall measure. Analyses were performed using an average of these two deviation scores (chunks and single words) to account for the fact that some participants might have recalled words in chunks while others might have recalled single words. Additional analyses were performed using both chunk and single word deviation scores (see Chapter 5).

Behavioral assessment. Behavioral countertransference was assessed using the approach-avoidance method pioneered by Bandura, Lipsher, and Miller (1960) and more recently used in countertransference research (e.g., Gelso et al., 1995; Harbin, 2004; Hayes & Gelso, 1993; Latts & Gelso, 1995). Approach responses are those that facilitate further client exploration (i.e., approval, exploration, reflection, and labeling), whereas avoidance responses are those that inhibit, discourage, or divert further exploration (i.e., disapproval, silence, ignoring, mislabeling, and topic transition). A ratio of the avoidance

responses to the sum of approach and avoidance responses was obtained to determine the frequency with which therapists gave avoidance responses. The response mode categories (i.e., categories of approach and avoidance responses) are presented in Appendix G (page 111).

Therapist responses to the video client were audiotaped, and the researcher, who is experienced with using the Hill coding system, broke transcribed therapist responses down into units following Hill and her colleagues (Hill, 1985). Each unit was then coded by a team of trained coders as one of the possible approach or avoidance responses. The coders were two doctoral-level graduate students and one masters-level graduate student (the researcher) in counseling psychology. The researcher led a two-hour training session of the coding team in which she explained the approach-avoidance measure. The script the researcher used in leading this coding team is presented in Appendix G (page 113). The coding team practiced on transcripts until a sufficient level of agreement among the raters was obtained (r of at least .80 for each of the three pairs of raters).

Each coder then coded 22 or 23 of the 35 transcripts such that each transcript was rated by two coders. Coders rated approach versus avoidance at both the unit level and at the overall speaking turn level. For example, if the first counselor speaking turn was comprised of three units, the coder would code each of the three units and, in addition, code the overall speaking turn as belonging to one of the approach or avoidance categories. Based on the coders' categorizations, the researcher then rated each unit and speaking turn as approach or avoidance. The correlation of approach-avoidance scores between coders one and two was .85 at the unit level and .80 at the speaking turn level; the correlation between coders one and three was .83 at the unit level and .81 at the

speaking turn level; and the correlation between coders two and three was .81 at the unit level and .81 at the speaking turn level. These correlations are at least as high as correlations found in similar studies, for example, .76 (Gelso, Fassinger, Gomez, & Latts, 1995).

For each transcript, the approach-avoidance scores for each of the two coders were averaged at the unit and speaking turn level to give an approach-avoidance score for each unit and speaking turn. The ratio of avoidance to total responses was then calculated at both the unit and speaking turn levels, and these ratios are an indication of behavioral countertransference in the session. From now on they will be referred to as “avoidance scores.” Both unit- and speaking turn-level scores were calculated for the following reason. A counselor’s speaking turn may contain several units that are avoidant, yet the overall impression of the speaking turn is not avoidant. Alternatively, few or none of the units within a speaking turn may be avoidant, but the whole speaking turn may come across as avoidant, for example, disapproving or neglectful of client affect. Thus, speaking-turn level avoidance scores may be more appropriate indices of behavioral countertransference in a session than unit-level scores. Analyses were primarily performed using speaking-turn level avoidance scores, although additional analyses were performed using unit-level scores (see Chapter 5).

Gelso et al. (1995) and Hayes and Gelso (1993) found hypothesized effects using this method in that homophobic counselors exhibited greater avoidance behavior with gay and lesbian clients than with heterosexual clients. These studies support the construct validity of this measure of behavioral countertransference.

Procedure

Participant Recruitment. Participants were women graduate students recruited from the counseling psychology, clinical psychology, school psychology, social work, rehabilitation counseling, and college student personnel programs at the University of Maryland. Participants were recruited in one of several ways. Participants in the counseling and clinical psychology programs were contacted via email by the researcher. Participants from the school psychology program were recruited via email by a friend of the researcher, and interested parties then contacted the researcher. Participants from the social work program were recruited by placing flyers for the study in the mailboxes of social work students interning at the University of Maryland Health Center. Lastly, initial participants from the rehabilitation counseling and college student personnel programs signed up on a sign up sheet to be potential participants at the end of the first practicum course. Those who signed up were then contacted via email by the researcher. Participants from these programs were asked to forward the researcher's email to their peers, and those who were interested in participating then contacted the researcher. Participants were invited to participate in a study on women counselors that would take approximately one hour. The first 35 women who volunteered to participate were subjects in the study. Subjects participated in the study one at a time. Participation times were set up individually via email. Scheduling was done on the basis of participant and researcher availability. Subjects were compensated 10 dollars for their participation.

Data Collection. Participants came to the counseling psychology laboratory on the day and time of their appointment. They were greeted by the researcher and asked to sit in the laboratory room where the analogue videos were filmed. The script the

researcher used to interact with participants is presented in Appendix H (page 116). Participants first completed an informed consent form (Appendix I, page 119), and then they were given a packet of questionnaires. The researcher explained to participants that the study involves their interaction with two videotaped clients, but that before viewing the tapes they were to complete a questionnaire packet. The questionnaire packet included the Body Dissatisfaction subscale of the Eating Disorders Inventory-3 (EDI-3 BD subscale). Measures of universal-diverse orientation, social desirability, working with client strengths, and adult attachment in romantic relationships were also included in the packet and served as distracters from the true purpose of the study. There were three forms of the questionnaire packet to control for order effects. These three packets were constructed in the following way. In each form, the EDI-3 BD subscale was included as the third measure with two of the distracter measures both before and after it. The measures one, two, four, and five (i.e., the distracter measures) were counterbalanced on either side of the EDI-3 BD subscale. Participants were assigned one of the three packets such that the first participant was assigned the first packet, the second participant was assigned the second packet, the third participant was assigned the third packet, and the cycle was then repeated.

Once participants completed the questionnaires, the researcher instructed them about the videotape portion of the study. The researcher instructed participants to imagine that they were meeting with a real client whom they had previously seen four times and with whom they had already established a good relationship. Subjects read a case summary of the warm-up client. After reading the case summary, participants viewed the videotape of the warm-up client. They were asked to respond at five predetermined pause

points in the videotape to the clients as if they were actually in a counseling session. They were told that their responses would be audiorecorded but would remain anonymous. As mentioned above, the purpose of this warm-up client was to familiarize participants with the analogue process, get baseline state anxiety information about participants, and throw the participants off as to the true purpose of the study. There were four possible warm-up client videotapes corresponding to the four actresses in the study. The client script was the same in all videos. Participants were assigned to a warm-up tape such that the first participant saw the first actress, the second participant saw the second actress, the third participant saw the third actress, the fourth participant saw the fourth actress, and the cycle was then repeated.

After participants viewed and responded to the first videotaped client, the researcher stopped the videotape and asked participants to complete two brief questionnaires. The first of these questionnaires was the State Anxiety Inventory (SAI), and the second was the one-item measure of cognitive countertransference described above. As described above, this question asked how many words related to the first client's presenting concern, depression, the client used.

The participants then read a case summary of the second client. Again, the researcher instructed participants to imagine that were meeting with a real client whom they had previously seen four times and with whom they had already established a good relationship. The second client was the stimulus client, the woman client with body image concerns. For the second client, there were four possible tapes corresponding to the two client body type conditions and the two actresses in each condition. Participants were assigned to one of the four conditions such that the first participant saw the first

ideal-far client, the second participant saw the first ideal-close client, the third participant saw the second ideal-far client, and the fourth participant saw the second ideal-close client. The cycle was then repeated. It was ensured that none of the participants saw the same actress in the warm-up tape as she saw in the stimulus tape. For the stimulus video, participants were asked to respond to the clients at seven predetermined pause points in the videotape as if they were actually in a counseling session. The second video lasted approximately eight minutes.

After participants viewed and responded to the second videotaped client, the researcher again stopped the videotape and asked participants to complete a packet of four questionnaires. The first questionnaire was the SAI; the second questionnaire was the one-item measure of cognitive countertransference. For the second client, this question asked how many words related to body, weight, or appearance (e.g., words such as ass, slim, or repulsive) the client used with respect to her appearance. The third questionnaire was the manipulation check described above asking participants to rate the BMI of the stimulus client. Lastly, participants completed a demographic form (Appendix K, page 122). After completing this packet, the researcher gave participants a debriefing form (Appendix L, page 123), thanked them for their participation, and asked them not to discuss the study with other potential participants.

CHAPTER 5

RESULTS

Manipulation Check

Before conducting the analyses of the hypotheses stated in Chapter 3, the manipulation check of client physique was examined. Participants were asked to rate the Body Mass Index (BMI) of the stimulus client they saw on a 7-point Likert scale, where 1 = *normal/light*, $BMI=18.5$, 4 = *normal/moderate*, $BMI=21.7$, and 7 = *normal/heavy*, $BMI=24.9$. The mean BMI for the ideal-close actresses was 3.18 ($SD = 1.38$), and the mean BMI for the ideal-far actresses was 5.44 ($SD = .92$). A oneway ANOVA was performed of actress on BMI rating. The omnibus test was significant at the .05 level of significance, $F(3, 31) = 13.05$, $p < .001$. Four post hoc contrasts using a Bonferroni correction to control the overall error rate at .05 were performed. These contrasts tested for mean BMI differences between ideal-close and ideal-far actresses, (e.g., BMI of ideal-close actress one versus BMI of ideal-far actress two). All four contrasts were significant. In addition, there were no significant differences in BMI within client physique conditions. These results suggest that the manipulation of client physique was accomplished.

Actress Effects

Potential actress effects were also examined prior to conducting the main analyses. t tests were performed between the two actresses within each client physique condition for each dependent variable. Six t tests were performed in all (corresponding to two actresses by two conditions by three dependent variables). Means and standard deviations of each dependent variable for each actress condition are presented in Appendix O Table 1 (page 128), and the results of the six t tests are presented in

Appendix O Table 2 (page 128). In the case of actress effects, Type II error (not finding a difference between actresses when a difference in fact exists) is a more egregious error than is Type I error (finding a difference between actresses when no difference exists). Thus, these t tests were performed at the .10 level of significance. No significant differences were found between actresses in either client physique condition for any of the dependent variables. The actress conditions were therefore collapsed within client physique conditions.

Main Analyses

Following Biskin (1980), the present study may be classified as a Class II study in that the three dependent measures (the State Anxiety Inventory, the cognitive recall measure, and the avoidance measure) are all measures of one conceptual dependent variable (countertransference). In the case of a Class II study, the dependent measures are expected to be highly correlated because they are all measures of the same conceptual variable. In such cases, univariate statistics are inappropriate because they ignore the correlations among the dependent measures. In Class II studies where the dependent measures are correlated, a multivariate analysis (MANOVA) is preferred. However, according to Biskin, it is appropriate to use univariate analyses in a multivariate study when the dependent measures are not highly correlated. The correlations between the dependent variables in the present study are presented in Table 1. Univariate analyses were performed because none of these correlations is significant. Following Jones and Gelso (1988), each of the three univariate analyses were conducted at the .05 level of significance.

Table 1Intercorrelations between Dependent Variables

	State	Cog.	Turn
Variables	Anx.	Recall	Avoid.
State Anx.	1	.02	-.17
Cog. Recall		1	-.02
Turn Avoid.			1

* = $p < .05$

State Anx. = Stimulus State Anxiety Inventory; Cog. Recall = Average Cognitive Recall;

Turn Avoid. = Speaking Turn Avoidance

The lack of significant correlations between the dependent measures makes theoretical sense. Affective and cognitive countertransference reactions are internal countertransference reactions, whereas behavioral countertransference reactions are external. These qualitatively different types of reactions are not necessarily expected to be correlated. For example, a counselor might have an internal countertransference reaction that he or she effectively manages. In this case, the counselor might experience affective and/or cognitive countertransference but display no behavioral countertransference in the session. What is more, affective reactions can be seen as separate from cognitive reactions. For example, a counselor might successfully manage his or her anxiety by focusing on what the client is saying. This strategy might lead to excellent recall of client material despite counselor anxiety in the session. Although affective, cognitive, and behavioral countertransference reactions are all manifestations of countertransference, they are conceptually different countertransference manifestations.

Three sets of hypotheses were tested in the present study. The first set of hypotheses proposed that counselor body image dissatisfaction would be positively related to counselor countertransference in the analogue session. Specifically, (a) counselor body image dissatisfaction was hypothesized to be positively related to counselor state anxiety immediately following the session; (b) counselor body image dissatisfaction was hypothesized to be positively related to counselor cognitive distortion immediately following the session; and (c) counselor body image dissatisfaction was hypothesized to be positively related to counselor avoidance during the session.

The second set of hypotheses proposed that client physique would be related to counselor countertransference in the analogue session such that counselors who saw an ideal-close client would experience more countertransference than would counselors who saw an ideal-far client. Specifically, (a) counselors who saw an ideal-close client were hypothesized to experience more state anxiety immediately following the session than counselors who saw an ideal-far client; (b) counselors who saw an ideal-close client were hypothesized to experience more cognitive distortion immediately following the session than counselors who saw an ideal-far client; and (c) counselors who saw an ideal-close client were hypothesized to experience more avoidance during the session than counselors who saw an ideal-far client.

The third set of hypotheses proposed an interaction between counselor body image dissatisfaction and client physique. It was hypothesized that counselor body image dissatisfaction would moderate the relationship between client physique and countertransference such that counselors who were high on body image dissatisfaction would experience significantly more countertransference in the analogue session with an ideal-close client than with an ideal-far client, whereas counselors who were low on body image dissatisfaction would not experience much countertransference in the analogue session with either an ideal-close or an ideal-far client. Specifically, (a) counselors who were high on body image dissatisfaction would experience significantly more state anxiety immediately following a session with an ideal-close client than with an ideal-far client, whereas counselors who were low on body image dissatisfaction would not experience much state anxiety with either client; (b) counselors who were high on body image dissatisfaction would experience significantly more cognitive distortion

immediately following a session with an ideal-close client than with an ideal-far client, whereas counselors who were low on body image dissatisfaction would not experience much cognitive distortion with either client; and (c) counselors who were high on body image dissatisfaction would experience significantly more avoidance during a session with an ideal-close client than with an ideal-far client, whereas counselors who were low on body image dissatisfaction would not experience much avoidance with either client.

Seventeen participants saw an ideal-close client, whereas 18 participants saw an ideal-far client. The mean of counselor body image dissatisfaction (Eating Disorders Inventory-3 Body Dissatisfaction subscale) in the sample was 12.49 ($SD = 8.41$). This mean is much lower than the mean reported by Garner (2004) for a clinical sample of patients with anorexia nervosa-restricting type ($M = 24.06$, $SD = 12.21$). The intercorrelations between the two independent variables (counselor body image dissatisfaction and client physique) and the three dependent variables (state anxiety, cognitive recall, and avoidance) are presented in Table 2. None of the correlations between any of these variables was significant at the .05 level of significance. Measures of central tendency and variability for the dependent variables, both overall and by client physique condition, are presented in Table 3. The means and standard deviations for state anxiety and cognitive recall are similar to means and standard deviations found in previous, similar studies (e.g., Gelso, Fassinger, Gomez, & Latts, 1995). The mean of avoidance is less in the present study, however, than means for avoidance found in previous, similar studies (e.g., Gelso et al.; Harbin, 2004). Although the present sample may have had similar amounts of anxiety and cognitive distortion as

Table 2Intercorrelations between Independent and Dependent Variables

Variables	BD	CP	State Anx.	Cog. Recall	Turn Avoid.
BD	1	.17	.10	-.16	.04
CP		1	.25	.02	-.07
State Anx.			1	.02	-.17
Cog. Recall				1	-.02
Turn Avoid.					1

* = $p < .05$

BD = Eating Disorders Inventory-3 Body Dissatisfaction subscale; CP = Client Physique Condition (Ideal-close or Ideal-far); State Anx. = Stimulus State Anxiety Inventory; Cog. Recall = Average Cognitive Recall; Turn Avoid. = Speaking Turn Avoidance

Table 3

Measures of Central Tendency and Variability for Dependent Variables both Overall and by Client Physique Category (Ideal-close or Ideal-far)

<u>Variable</u>	<u>Central Tendency</u>		<u>Variability</u>		
	Mean	Median	SD	Range	Possible Range
State Anxiety	39.49	40	10.28	20-64	20-80
Ideal-close	36.88	38	8.82	23-50	20-80
Ideal-far	41.94	42.5	11.17	20-64	20-80
Cognitive Recall	18.56	20.5	7.58	3-40	N/A
Ideal-close	18.44	20.5	6.28	5-28	N/A
Ideal-far	18.67	20.5	8.81	3-40	N/A
Turn Avoidance	16.12	7.14	21.94	0-85.71	0-100
Ideal-close	17.65	14.29	26.50	0-85.71	0-100
Ideal-far	14.68	7.14	17.23	0-57.14	0-100

samples in similar studies, they may have exhibited less avoidance behavior in the analogue session.

To test the first set of hypotheses, simple Pearson product-moment correlation coefficients were calculated for counselor Eating Disorders Inventory-3 Body Dissatisfaction subscale (EDI-3 BD subscale) score with each of the three dependent measures: counselor State Anxiety Inventory (SAI) stimulus score (i.e., the counselor's score on the SAI filled out after viewing the stimulus client), counselor cognitive recall score, and counselor avoidance score. The average of the two types of cognitive recall scores (chunks and single word scores) was used to account for the fact that some participants may have recalled expressions such as "gross fatso" as one word "chunk" whereas other participants may have recalled "gross fatso" as two individual words. Speaking turn avoidance scores were used because they are a better indicator of countertransference in the session for reasons discussed in Chapter 4. These correlations are presented in Table 2. As stated above, none of these correlations was significant at the .05 level of significance.

To test the second set of hypotheses, three t tests were conducted to compare scores on each of the dependent measures (stimulus SAI score, average cognitive recall score, and speaking turn avoidance score) of counselors who saw an ideal-close client to scores of counselors who saw an ideal-far client. The results of these t tests are presented in Table 4. None of these t tests was significant at the .05 level of significance.

Three hierarchical multiple regressions were used to test further the first two sets of hypotheses as well as the third set of hypotheses for each of the dependent variables (stimulus SAI score, average cognitive recall score, and speaking turn avoidance score).

Table 4t tests of Client Physique Effect

<u>Physique Conditions</u>	<u>State Anx.</u>	<u>Cog. Recall</u>	<u>Turn Avoid.</u>
Ideal-close vs. Ideal-far	t = -1.48	t = -.09	t = .40

* = $p < .05$

State Anx. = Stimulus State Anxiety Inventory; Cog. Recall = Average Cognitive Recall;

Turn Avoid. = Speaking Turn Avoidance

Multiple regression procedures were chosen over ANOVA procedures because they offered superior power in the present study. Counselor EDI-3 BD subscale score could be entered as a continuous variable in a regression analysis rather than arbitrarily dividing the sample into high and low groups as would have been necessary if ANOVA methods had been used.

The criterion variable in the first regression was counselor State Anxiety Inventory (SAI) stimulus score. The predictors in the first step were client physique (dummy coded as 0 = ideal-close and 1 = ideal far) and counselor EDI-3 BD subscale score. The interaction between client physique and EDI-3 BD subscale was entered in the second step so as to partial out from the interaction term the variance due to the main effects. The regression model was not significant at either step, $F(2, 32) = 1.13$, $p = .34$ and $F(3, 31) = 1.86$, $p = .16$ respectively. The results of this regression are presented in Table 5. Since the overall model was not significant, no post hoc analyses were performed.

The regression was also performed with counselor SAI warm-up score (i.e., the counselor's score on the SAI filled out after viewing the warm-up client) as a covariate. The warm-up client's presenting problem (romantic relationship break-up) was typical of a college student and expected to be familiar to all participants in the study. A counselor's anxiety after viewing this client may be thought of as a "baseline" or trait anxiety score for the participant. Analyzing warm-up anxiety as a covariate partialled out variance in stimulus anxiety due to counselor trait anxiety from variance in stimulus anxiety due to countertransference. The counselor's SAI warm-up score was entered in the first step, counselor EDI-3 BD subscale score and client physique condition were

entered in the second step, and the interaction between EDI-3 BD subscale score and client physique condition was entered in the third step. The regression model was significant at all three steps, $F(1, 33) = 15.03, p = .00$; $F(3, 31) = 6.11, p = .00$; and $F(4, 30) = 4.50, p = .00$ respectively. However, only SAI warm-up score significantly accounted for any of the variance in SAI stimulus score in all three steps. The results of this regression are presented in Table 6.

The criterion variable in the second regression was counselor average cognitive recall score. As before, client physique and counselor EDI-3 BD subscale score were entered first followed by the interaction term. The regression model was not significant at either step, $F(2, 32) = .46, p = .64$ and $F(3, 31) = .98, p = .42$ respectively. The results of this regression are presented in Table 7. Since the overall model was not significant, no post hoc analyses were performed. As with stimulus anxiety, the regression was also performed controlling for warm-up anxiety. The amount of general, trait anxiety a counselor experiences may affect his or her ability to recall session content regardless of counselor countertransference. Analyzing warm-up anxiety as a covariate controls for this potential, unwanted effect. The regression model was not significant at all three steps, $F(1, 33) = .49, p = .49$; $F(3, 31) = .53, p = .66$; and $F(4, 30) = 1.36, p = .27$ respectively. The results of this regression are presented in Table 8. Four additional regressions were also performed with cognitive recall chunk scores and cognitive recall single word scores as the criterion variables both controlling for and not controlling for warm-up anxiety. None of these regressions was significant.

The criterion variable in the last regression was counselor speaking turn avoidance. As before, client physique and counselor EDI-3 BD subscale score were

Table 5

Results of Regression on Stimulus State Anxiety Inventory score

<u>Variable</u>	β	R^2	F_R^2	$\text{Inc. } R^2$	$F_{\text{Inc. } R^2}$
<hr/>					
<i>Step 1:</i> BD + CP		.07	1.13	N/A	N/A
BD	.06				
CP	.24				
<i>Step 2:</i> BD x CP		.15	1.86	.09	3.16

* = $p < .05$

BD = Eating Disorders Inventory-3 Body Dissatisfaction subscale; CP = Client Physique Condition (Ideal-close or Ideal-far)

Table 6

Results of Regression on Stimulus SAI score controlling for Warm-Up Anxiety

<u>Variable</u>	β	R^2	F_R^2	$\text{Inc. } R^2$	$F_{\text{Inc. } R^2}$
<hr/>					
<i>Step 1:</i> W-U Anx.		.31	15.03*	N/A	N/A
<i>Step 2:</i> BD + CP		.37	6.00*	.06	1.34
BD	-.02				
CP	.24				
<i>Step 3:</i> BD x CP		.38	4.50*	.09	.37

* = $p < .05$

W-U Anx. = Warm-Up State Anxiety Inventory; BD = Eating Disorders Inventory-3

Body Dissatisfaction subscale; CP = Client Physique Condition (Ideal-close or Ideal-far)

Table 7

Results of Regression on Average Cognitive Recall score

<u>Variable</u>	β	R^2	F_R^2	$\text{Inc. } R^2$	$F_{\text{Inc. } R^2}$
<i>Step 1: BD + CP</i>		.03	.46	N/A	N/A
BD	-.17				
CP	.04				
<i>Step 2: BD x CP</i>		.09	.98	.06	2.00

* = $p < .05$

BD = Eating Disorders Inventory-3 Body Dissatisfaction subscale; CP = Client Physique Condition (Ideal-close or Ideal-far)

Table 8

Results of Regression on Cognitive Recall score controlling for Warm-Up Anxiety

<u>Variable</u>	β	R^2	F_R^2	$\text{Inc. } R^2$	$F_{\text{Inc. } R^2}$
<i>Step 1: W-U Anx.</i>		.02	.49	N/A	N/A
<i>Step 2: BD + CP</i>		.05	.53	.03	.56
BD	-.19				
CP	.04				
<i>Step 3: BD x CP</i>		.15	1.36	.10	3.70

* = $p < .05$

W-U Anx. = Warm-Up State Anxiety Inventory; BD = Eating Disorders Inventory-3

Body Dissatisfaction subscale; CP = Client Physique Condition (Ideal-close or Ideal-far)

entered first followed by the interaction term. The regression model was not significant at either step, $F(2, 32) = .12, p = .88$ and $F(3, 31) = .13, p = .94$ respectively. The results of this regression are presented in Table 9. Since the overall model was not significant, no post hoc analyses were performed. As with stimulus anxiety and cognitive recall, the regression was also performed controlling for warm-up anxiety. The amount of general, trait anxiety a counselor experiences may affect his or her ability to respond effectively in the session regardless of counselor countertransference. Analyzing warm-up anxiety as a covariate controls for this potential, unwanted effect. The regression model was not significant at all three steps, $F(1, 33) = 1.02, p = .32$; $F(3, 31) = .39, p = .76$; and $F(4, 30) = .46, p = .76$ respectively. The results of this regression are presented in Table 10. Two additional regressions were performed with unit avoidance scores as the criterion variable both controlling for and not controlling for warm-up anxiety. Neither of these regressions was significant. In sum, none of the three sets of hypotheses was supported.

Additional Analyses

The correlations between therapist theoretical orientation and the three dependent measures (stimulus anxiety, average cognitive recall, and speaking turn avoidance) were examined. Research has suggested that therapists who adhere to differing theoretical orientations may have different personality characteristics (e.g., Tremblay, Herron, & Schultz, 1986). In turn, these different personalities may affect counselors' reactions in a counseling session. Therapist theoretical orientation was assessed by asking participants to rate the degree to which they adhered to the techniques of three theoretical orientations—psychoanalytic/psychodynamic, experiential/humanistic/existential, and behavioral/cognitive behavioral—on separate 5-point Likert scales, where 5 = *very high*

Table 9

Results of Regression on Speaking Turn Avoidance score

<u>Variable</u>	β	R^2	F_R^2	$\text{Inc. } R^2$	$F_{\text{Inc. } R^2}$
<i>Step 1: BD + CP</i>		.008	.12	N/A	N/A
BD	.06				
CP	-.08				
<i>Step 2: BD x CP</i>		.013	.13	.005	.15

* = $p < .05$

BD = Eating Disorders Inventory-3 Body Dissatisfaction subscale; CP = Client Physique Condition (Ideal-close or Ideal-far)

Table 10

Results of Regression on Avoidance score controlling for Warm-Up Anxiety

<u>Variable</u>	β	R^2	F_R^2	$\text{Inc. } R^2$	$F_{\text{Inc. } R^2}$
<i>Step 1: W-U Anx.</i>		.03	1.02	N/A	N/A
<i>Step 2: BD + CP</i>		.04	.39	.01	.10
BD	.03				
CP	-.08				
<i>Step 3: BD x CP</i>		.06	.50	.02	.70

* = $p < .05$

W-U Anx. = Warm-Up State Anxiety Inventory; BD = Eating Disorders Inventory-3

Body Dissatisfaction subscale; CP = Client Physique Condition (Ideal-close or Ideal-far)

belief. Scores on each of these theoretical orientations were correlated with scores for the three dependent variables. These correlations are presented in Appendix P Table 1 (page 129). None of these correlations was significant at the .05 level of significance.

Partial correlations between the three theoretical orientations and the three dependent variables controlling for warm-up anxiety and an index of experience (number of supervised women client hours) were also calculated. Counselors' trait anxiety as well as their experience level may potentially obscure the relationship between theoretical orientation and the dependent variables. These correlations are reported in Appendix P Tables 2 and 3 respectively (pages 130 and 131). When warm-up anxiety was partialled out, the correlation between counselor endorsement of behavioral/cognitive behavioral therapy and speaking turn avoidance was significant ($r = .40, p = .02$). Thus, the more counselors adhered to the techniques of behavioral/cognitive behavioral therapy, the more avoidance they exhibited in the analogue session. When experience was partialled out, the correlation between counselor endorsement of behavioral/cognitive behavioral therapy and speaking turn avoidance was again significant ($r = .35, p = .05$), and the correlation between counselor endorsement of psychoanalytic/ psychodynamic therapy and stimulus anxiety was significant ($r = .41, p = .02$). Thus, the more counselors adhered to the techniques of psychoanalytic/psychodynamic therapy, the more anxiety they experienced in the analogue session.

The correlations between therapist experience and the three dependent measures (stimulus anxiety, average cognitive recall, and speaking turn avoidance) were also examined. Therapists who are less experienced may feel more anxious in a session, have more trouble recalling client material, and may exhibit more avoidance behavior in a

session than more experienced counselors regardless of countertransference. Therapist experience was operationalized in four different ways: number of supervised clients seen, number of supervised client hours, number of supervised women clients seen, and number of supervised women client hours. The results of these correlations are presented in Appendix Q Table 1 (page 132). None of these correlations was significant. Partial correlations between the four indices of experience and the three dependent variables controlling for warm-up anxiety were also calculated. Counselor trait anxiety may obscure the relationship between counselor experience and the dependent variables. The results of these correlations are presented in Appendix Q Table 2 (page 133). None of these correlations was significant.

CHAPTER 6

DISCUSSION

Body image dissatisfaction is an unfortunately common problem among women in today's society. Counselors, who may themselves suffer from body image dissatisfaction, are likely to see women clients who present with body image concerns. The present study examined the role of counselor body image dissatisfaction and client physique on counselor countertransference. In this section, the results presented in Chapter 5 will be discussed and limitations and directions for future research will be presented.

The Effect of Counselor Body Image

In the present study, counselor body image as operationalized by the Eating Disorders Inventory-3 Body Dissatisfaction subscale (EDI-3 BD subscale) was not found to predict significantly counselor scores on measures of affective, cognitive, and behavioral countertransference reactions. It was hypothesized that counselor body image dissatisfaction would be positively related to counselor countertransference. Countertransference is theorized to occur when client material touches on unresolved counselor issues (in the present case, body image concerns). Thus, it was expected that counselors with higher scores on the EDI-3 BD subscale (i.e., counselors who reported greater body image dissatisfaction) would experience more countertransference in the analogue session. Several alternative explanations can be posited for these null findings.

Body image problems are a popular topic in the media. Research such as Garner, Garfinkel, Schwartz, and Thompson's (1980) study on the percentage of space in women's magazines devoted to diet and/or exercise suggests that the media has

increasingly encouraged women to conform to a nearly impossible ideal. However, such research neglects the recent trend in the media toward acknowledging the disproportionate emphasis placed on women's appearances. For example, the April, 2006, issue of *Glamour* magazine is touted as "The Reality Issue" and claims to expose the behind-the-scenes airbrushing and retouching of photographs commonly found in women's magazines. In a featured article, "Why Does Everyone Look So Fake?" makeup artist Bobbi Brown bemoans what she calls the "disturbing" increase in plastic surgery (p. 276). Glancing through almost any recent issue of any major women's magazine yields similar results: there appears to be a backlash in the media against the societal ideal of beauty. What is more, the beauty product company Dove recently launched its "Campaign for Real Beauty." The campaign uses women of all shapes and sizes in its advertisements. In the campaign's mission statement, Dove states, "Dove believes all girls deserve to see how beautiful they really are and is committed to raising self-esteem in girls everywhere" (Dove, 2006, ¶ 1). These trends in the media may have served to heighten all women's awareness about the physical and psychological problems associated with body image dissatisfaction.

The counselors in the present study may have been particularly influenced by these "body positive" messages because of their sensitivity to mental health issues. These media messages may have spurred the counselors in the present study to consider and work through their own body image concerns. According to Gelso and Hayes's (in preparation) definition of countertransference, countertransference cannot occur when the issue in question is no longer unresolved for the therapist. If the counselors in the present

study had successfully worked through their own body image concerns, then they would not be expected to have experienced countertransference in the session.

Furthermore, counselors are in general more attuned to their own psychological issues, and many graduate programs encourage trainees to seek their own personal psychotherapy. The counselors in the present study are likely no exception. With or without the media's influence, the counselors may have worked through their own issues regarding body image, or at least be aware enough of them to prevent their manifestation in the form of countertransference reactions.

Indeed, body image dissatisfaction was not high in the sample. The mean score on the EDI-3 BD subscale was 12.49 ($SD = 8.41$). As mentioned in Chapter 5, the mean score in a clinical sample with anorexia nervosa-restricting type was 24.06 ($SD = 12.21$; Garner, 2004). The mean clinical sample score is almost one and a half standard deviations above the present sample mean. It seems that, compared to women with an eating disorder, the counselors in the present study experienced significantly less body image dissatisfaction. The hypothesis presented in Chapter 3 regarding the interaction effect posited that counselors low on body image dissatisfaction would experience little countertransference with either an ideal-close or an ideal-far client. In light of this hypothesis, the null results for counselor body image dissatisfaction make sense. The vast majority of the counselors were low on body image dissatisfaction, and they did not experience much countertransference.

The Effect of Client Physique

Client physique, operationalized as ideal-close and ideal-far, did not significantly predict counselor countertransference. It was hypothesized that counselors would

experience more countertransference with an ideal-close than with an ideal-far client. Through social comparison, counselors were expected to compare themselves to the client on the dimension of body image. This comparison was expected to be an upward comparison (i.e., a social comparison in which one compares oneself to someone who is superior on a given dimension) in the case of an ideal-close but not an ideal-far client. Countertransference was therefore expected to be heightened for counselors who saw an ideal-close client. Several explanations are possible as to why this hypothesis was not supported.

Previous studies on countertransference using this analogue method have examined counselors' reactions to clients unlikely to be commonly encountered at a college counseling or health center, e.g., a lesbian client describing sexual concerns and a middle-aged African-American mental health worker. However, body image dissatisfaction is a "normative discontent" among women, particularly adolescent and college-aged women (Rodin, Silberstein, & Striegel-Moore, 1984). College-aged women with body image concerns are likely to be consumers of campus mental health services. Many of the participants in the study have had their practicum courses at college counseling and/or health centers. They may have frequently encountered the client concern presented in this study. What is more, although client physique was manipulated, both conditions (ideal-close and ideal-far) were within the normal Body Mass Index (BMI) range. The actresses in both conditions looked like typical college students. Thus, the participants' experience with this client presenting concern and presenting style (i.e., physique) may have allowed them to manage effectively any countertransference reactions they had in the session, producing null results. Perhaps if the clients had

appeared unusual or unhealthy for their age group (e.g., emaciated or obese), counselors would have experienced heightened countertransference.

Examining the correlations between the independent and dependent variables reveals that the correlation between client physique and stimulus state anxiety approached significance ($r = .25$, $p = .15$). However, this effect was in the opposite direction from the direction hypothesized: counselors reported more state anxiety after viewing an ideal-far than an ideal-close client. Although no conclusions can be drawn since this result was not significant, two possible explanations for this correlation are presented.

First, counselors presented with an ideal-close client viciously disparaging her appearance may have had an easier time conceptualizing the client's problem as body image-related than counselors presented with an ideal-far client. The actresses portraying the ideal-close client were clearly not overweight. Thus, the counselors may have immediately seen the client's problem as psychological. They may have begun to conceptualize the client as having body image concerns, including distorted perception and perhaps disordered eating, early in the analogue session. Counselors who saw an ideal-far client, however, may have had difficulty determining if the client's problem was psychological or physical. The first actress in the ideal-far condition in particular was at the extreme heavy end of the normal BMI range. The counselors may have spent more time debating whether or not the client's concerns were legitimate in the case of an ideal-far client. They would therefore have spent less time in the session conceptualizing the client's problem. VanWagoner, Gelso, Hayes, and Diemer (1991) identified conceptualizing ability as a key component in countertransference management.

Counselors in the present study who saw an ideal-close client may have been able to conceptualize the client's problem. They may have therefore managed their anxiety effectively.

Alternatively, an ideal-far client may have been more likely to stir the counselors' own fears about weight and shape than an ideal-close client. As mentioned above, body image dissatisfaction is a common concern among young women. The actresses portraying the ideal-far client were at the high end of the normal BMI scale and therefore on the edge of being overweight. Counselors may have identified with the ideal-far client and even seen the client's physique as their "worst fear" (i.e., being overweight) realized. What is more, research has shown that women who misperceive their body's shape consistently see themselves as heavier than they are (Gray, 1977). Average-weight counselors with body image concerns in the sample may perceive themselves as being as heavy as the actresses portraying the ideal-far client. They may have more strongly identified with this client than with an ideal-close client, and this identification may have stirred their own body image issues. This "stirring" of issues may have led to increased anxiety in the session.

This difference in anxiety between counselors who saw an ideal-close versus an ideal-far client was not significant, so no conclusions can be drawn about it. However, if the study were replicated, it would be informative to include additional weight conditions to test the process of counselor identification with client proposed in the preceding paragraph. Adding additional client physique conditions, such as an average-weight condition, an overweight condition, and an obese condition, might support this possible effect of counselor identification. Counselors may be less likely to identify with

overweight and obese clients (unless they themselves are overweight or obese). Thus, they would be expected to experience less anxiety with these clients than with the ideal-far client presented in this study.

The Interaction of Counselor Body Image Dissatisfaction and Client Physique

No interaction effect of counselor body image dissatisfaction and client physique on counselor countertransference was found in the present study. Counselor body image dissatisfaction was hypothesized to moderate the relationship between client physique and countertransference. Specifically, counselors who were high on body image dissatisfaction were expected to experience more countertransference with an ideal-close than with an ideal-far client, whereas counselors who were low on body image dissatisfaction were expected to experience little countertransference with either an ideal-close or an ideal-far client. As mentioned above, the majority of counselors in this study were low on body image dissatisfaction. According to the hypothesis just presented, they would not be expected to experience a difference in countertransference with an ideal-close versus an ideal-far client. The lack of interaction in this study can be explained by the low mean of counselor body image dissatisfaction in the sample. It is of course encouraging that most of the participants do not seem to suffer from body image problems. However, if more participants had suffered from body image concerns, perhaps an interaction between counselor body image dissatisfaction and client physique would have been found.

Additional Findings

The partial correlation between counselor endorsement of behavioral/cognitive behavioral therapy and speaking turn avoidance controlling for counselor warm-up

anxiety was significant ($r = .40, p = .02$). The partial correlation between counselor endorsement of behavioral/cognitive behavioral therapy and speaking turn avoidance controlling for counselor experience (i.e., number of women client hours) was also significant ($r = .35, p = .05$). Thus, when the effects of trait anxiety and experience are removed, counselors who endorsed behavioral/cognitive behavioral therapy seemed to exhibit more avoidance behavior in the analogue session. Research has shown that behavior therapists emphasize objectivity and detachment (e.g., Tremblay, Herron, & Schultz, 1986). Behaviorally-oriented counselors in the present study may have therefore shied away from the emotion-laden content of the session.

Furthermore, the partial correlation between counselor endorsement of psychoanalytic/psychodynamic therapy and stimulus anxiety controlling for counselor experience was significant ($r = .41, p = .02$). Thus, when the effect of experience is removed, counselors who endorsed psychoanalytic/psychodynamic therapy seemed to exhibit more anxiety in the analogue session. Research has shown that psychodynamic therapists stress inner subjective states and unconscious motivation (Tremblay et al.). Psychodynamically-oriented counselors in the present study may have been more in touch with their own subjective anxiety in the session than behaviorally or humanistically-oriented counselors were. The results of the present study therefore support the results of previous studies on the relationship between theoretical orientation and personality and extend these findings to the context of therapy with a client presenting with body image concerns.

Limitations

There are several limitations of the present study. First, the study is a laboratory analogue. As such, it is questionable whether the results may be generalized to actual therapy dyads. However, the analogue situation provided the control necessary to manipulate the independent variable of client physique, thereby adding to the study's internal validity. What is more, a series of analogue studies on countertransference (e.g., Gelso, Fassinger, Gomez, & Latts, 1995; Harbin, 2004; Hayes & Gelso, 1993; Latts & Gelso, 1995) has found hypothesized effects with this method. Several steps were also taken to make the analogue situation as realistic as possible. First, the study was a video analogue rather than an audio analogue. Video analogues (e.g., Gelso et al.) better approximate an actual therapy situation than do audio analogues (e.g., Robbins and Jolkovski, 1987). Following Harbin (2004), participants were alone in the room with the video so that no experimenter was present to overhear and potentially influence counselor responses to the video. Participants also read case summaries about the clients prior to watching the videos and were instructed to imagine that they had had four previous sessions with the clients. Lastly, participants watched the videos in the same room in which they were filmed, adding to the believability of the counseling scenario.

A second limitation of the study is the low sample mean on the EDI-3 BD subscale. As previously mentioned, the sample's mean was over a standard deviation less than the mean of a clinical group. Although there was variability in the sample on the EDI-3 BD subscale, there may not have been enough participants with serious body image issues to find as significant the hypothesized effect of counselor body image dissatisfaction on countertransference. However, women counselors with severe body

image issues may be rare. It is possible that many women counselors have worked through their own body image concerns. Unless women counselors with body image problems had been specifically targeted as participants, increasing sample size may not have increased the EDI-3 BD subscale mean.

There were also several limitations of the measures used in the study. Counselor body image dissatisfaction was measured using the EDI-3 BD subscale. This measure was chosen for three reasons. First, hypothesized effects have been found using the Eating Disorders Inventory-2 Body Dissatisfaction subscale (EDI-2 BD subscale). Second, it is a brief, pencil and paper measure, unlike some other measures of body image (e.g., the Body-Self Relations Questionnaire; Brown, Cash, & Mikulka, 1990). Third, it assesses three of the four dimensions in the author's definition of body image. However, this measure may not fully tap into the dimension of the construct of body image that is most salient for predicting countertransference. The items on the EDI-3 BD subscale assess primarily perceptual, affective, and cognitive dimensions of countertransference (e.g., "I like the shape of my buttocks"). However, the behavioral dimension is not assessed. The behavioral dimension of body image differentiates between clinical and non-clinical samples. Rosen, Srebnik, Saltzberg, and Wendt (1991) found that a measure of body image avoidant behavior (e.g., wearing baggy clothing) differentiated between clinical and non-clinical samples. Also, behaviors such as frequency of purging are necessary for a DSM-IV-R diagnosis of bulimia nervosa (American Psychiatric Association, 2000). The mean score on the EDI-3 BD subscale in the sample was quite low. A measure that tapped into the behavioral aspect of body image may have teased out which participants (if any) truly suffered from body image

disturbance, thereby increasing the range of body image dissatisfaction scores in the sample.

Client physique was operationalized as two conditions: ideal-close and ideal-far. Actresses in both conditions were within the normal, healthy BMI range. Normal-weight clients with body image problems may be a common client-type familiar to most counselors. The clients in this study may not have been unfamiliar and threatening to the counselors and therefore may not have increased the counselors' countertransference. In previous, similar studies, attempts have been made to make the client and his or her material as threatening to the counselor as possible. For example, in Harbin's (2004) study, an angry African-American male client yelled at and leaned in menacingly close to the camera. Although in the current study, the client viciously disparaged herself (e.g., she called herself a "gross fatso"), perhaps adding more client physique conditions (e.g., an emaciated condition, an obese condition) would have increased the threat to the counselor and by extension counselor countertransference.

The reliability of the cognitive recall measure is also questionable. The measure is appealing because it is free from the social desirability that can affect counselors' verbal responses and self-reported anxiety. What is more, Gelso, Fassinger, Gomez, and Latts (1995) found that women counselors who saw a lesbian client had more errors in recalling the number of sexual words used than did men counselors, whereas women and men counselors who saw a heterosexual woman client had similar error rates. However, no other study in a series of studies using a cognitive recall measure analogous to the measure used in this study has found hypothesized effects with the measure (e.g., Gelso & Latts, 1995; Harbin, 2004; Hayes & Gelso, 1993). Counselors may under- or overrecall

client material for a variety of reasons, some of which are unrelated to countertransference. For example, counselors who were tired may have had trouble recalling the number of body image-related words used in the session. Particularly in the artificial analogue setting, counselors may not have made as much of an effort to encode client material as they might have in a real counseling session. It is nearly impossible to separate these possible causes of under or over-recall from countertransference.

Lastly, the sample in the present study is not generalizable to the general population of therapists. Participants in the present study were graduate students in counseling-related fields, not licensed therapists. However, counselor body image dissatisfaction and client physique were not found to predict countertransference in the present sample. It is therefore reasonable to assume that more experienced, practicing clinicians will also not experience increased countertransference with clients of various body types presenting with body image concerns.

Directions for Future Research

Only 35 subjects participated in the present study. Collecting more subjects would increase the power of the study and thereby increase the chance of finding a significant effect of client physique on counselor stimulus anxiety. In the present study, the correlation between client physique and counselor stimulus anxiety was .25, and this correlation approached significance ($p = .15$). Client physique and counselor body image dissatisfaction (entered simultaneously in step one of the hierarchical multiple regression described in Chapter 5) accounted for approximately seven percent of the variance in counselor stimulus anxiety ($R^2 = .07$). Based on Cohen's (1988) guidelines, this amount of variance accounted for corresponds to a medium effect size ($f = .27$). With increased

power, such an effect could be found significant. Thus, more subjects could be recruited and added to the present sample.

It would also be interesting to replicate the present study with several other client physique conditions. Underweight, average-weight, overweight, and obese client conditions could be added to the current physique conditions. Although we cannot draw any conclusions because the mean difference was not significant, counselors seemed to have more anxiety in response to the ideal-far than the ideal-close client. As described above, the ideal-far clients were on the edge of being overweight. Through counselors' identification with the client, the ideal-far clients may have stirred counselors' anxiety about becoming overweight. It would be interesting to see if counselors had less anxiety with an overweight or obese client than with the ideal-far client presented in this study. It may be easier for counselors to distance themselves from overweight or obese clients (unless they themselves are overweight or obese), and they may therefore have less anxiety with these clients. Alternatively, working with an overweight or obese client might stir more counselor anxiety because such clients might provoke even more counselor fear and self-loathing. Future research may further investigate the construct of client physique by incorporating more client body-types.

In conclusion, the prevalence of "body positive" messages in the media, the low prevalence of body image disturbance in the sample and in counselors in general, the restriction of range of client physiques in the study, the artificial laboratory setting, and the choice of the EDI-3 BD subscale may have contributed to the study's null results. Future research may investigate the interesting, though not significant, relationship between client physique and counselor anxiety by including other client body types.

Body image concerns are a common problem among women in today's society; this important topic is worthy of future research.

Appendix A:

Warm-up Client Case Summary

Client Name: Sarah Mitchell

Age: 21

Gender: Female

Occupation: student

Presenting Problem: relationship breakup

Background Information:

Sarah is a 21 year old single White senior majoring in English at the University of Maryland. She grew up in Bethesda, Maryland with her parents and one younger brother. She got good grades in high school, played tennis on her school's varsity tennis team, and helped to care for her elderly grandmother who passed away four years ago. Sarah describes her relationship with her parents as "generally good," although she felt that they sometimes pushed her too hard academically. She also gets along well with her brother who is now a freshman at the University of Maryland.

Sarah came to counseling after her boyfriend of one year broke up with her. Her ex-boyfriend gave "wanting to be single for a while" as a reason for their breakup, although Sarah has stated that they fought frequently about "petty" things such as how much time to spend together versus with their friends. Sarah had hoped that she and her ex-boyfriend might get engaged after college, and the breakup came as a shock to her.

Since the breakup, Sarah has had difficulty sleeping and complains of headaches. She does not feel motivated in her classes or in her social life. Sarah sought your counseling services to deal with these difficulties and to work through her mixed feelings toward her ex-boyfriend.

Appendix B:

Warm-up Client Script

I think I really messed up a test yesterday in my sociology class. It was on the syllabus from the beginning of the semester, so I had no excuse not to prepare for it. I've just been feeling so tired lately that I didn't really put any effort into studying. Usually I study for at least a couple days before a test, but this time I waited until the night before, and even then I couldn't concentrate.

PAUSE

I just haven't felt motivated about anything. My friends asked me to hang out with them last Saturday night, but I didn't want to. They were going to the same bar we always go to, and I knew a lot of my friends would be there, but I just didn't feel like dealing with all those people. It's always so loud and crowded. I don't know. Usually I like that type of thing, but lately I haven't felt like it.

PAUSE

I also haven't been sleeping very well at all. I feel really tired all the time, but for some reason I just can't fall asleep when I go to bed. It's funny; I could fall asleep easily in any one of my classes, but when I actually want to go to sleep, I can't. I just start thinking about how John broke up with me, and I think about our last conversation and what I could have said differently.

PAUSE

I keep thinking about our relationship and wondering where I screwed up. I think I was a good girlfriend. I was always there for him when he needed me, and I did romantic stuff like cook him dinner. I thought he cared about me, but we just fought so

much. I guess I knew all along that we would probably break up eventually, but I tried not to think about it.

PAUSE

My roommates keep telling me that what I'm going through is normal. My friend Christine's boyfriend broke up with her a couple of months ago, and she was pretty depressed for a while, but now she's doing better. She said it'll get better, and I know she's right. But it sucks to feel like this right now.

PAUSE

(End of Script)

Appendix C:

Stimulus Client Case Summary

Client Name: Margaret Gibbons

Age: 22

Gender: Female

Occupation: student

Presenting Problem: career concerns and relationship insecurities

Background Information:

Margaret is a 22 year old single White senior majoring in history at the University of Maryland. She grew up in Stamford, Connecticut with her parents, older sister, and younger brother. Margaret is a solid student who is involved in the Student Government Association (SGA). Margaret describes her relationship with her parents as good but distant. As the middle of three children, she felt that she did not always get the attention she wanted from her parents growing up. She gets along well with her older sister who works in advertising in New York. Margaret states that she does not have much in common with her brother, who, as a high school sophomore, is considerably younger than Margaret.

Margaret sought your counseling services because of anxiety related to not knowing what she wants to do after graduation. Margaret eventually wants to go to graduate school, but she states that she wants to take time off after college to “see the world and save up some money.” She has considered applying to advertising companies in New York like her sister, but worries that advertising is too unrelated to her college major. Now that graduation is almost upon her, she regrets not having put in applications to graduate schools.

During your meetings with Margaret, it has come out that she is currently dating a man named Mike who is also a senior at the university. They have been dating for three months. Mike is also involved in the SGA, which is how they met. Margaret has described insecurities in her relationship with Mike and with previous boyfriends. She feels that she always does something to push men away. Although their dates have gone well so far, she worries that Mike will break up with her.

Appendix D:

Stimulus Client Script

I feel so awful; I can't concentrate on anything today. I totally screwed up my relationship with Mike last night, and I can't stop thinking about it. Yesterday was my birthday, and I was so excited to see what he had planned to do. Mike said he wanted to surprise me with a romantic evening. I've never had a guy do something so nice for me before, and I was starting to feel like Mike really liked me. That's what makes what I did so much more devastating, you know? Here I might have found the perfect guy, but I ruined it because I'm a fatso with no self-control.

PAUSE

I spent the whole afternoon getting ready because I wanted to look really hot, you know? I picked out this outfit that makes my butt look good and got my nails done. And even before that, for like the whole last week, I went to the gym every day and barely ate anything so that I wouldn't look so fat when we went out. I could just cry when I think about how hard I tried to look good for him.

PAUSE

Well after all that effort, I was starting to think I might look decent by the time Mike picked me up. He took me to this really fancy Italian restaurant and ordered expensive wine. I actually started to relax around him, and I even let myself have an appetizer and I ordered pasta with *alfredo* sauce. Before I knew it, I'd eaten the whole damn thing. I mean, usually I would never eat something like that in public, especially in front of a guy, but I wanted to reward myself for working so hard all week and really enjoy the night, you know?

PAUSE

Okay. Here's the worst part. When the waiter asked about dessert, I started to order the chocolate cake, and Mike interrupted me and asked for the check instead! He probably thought I'd eaten enough for one night. I was so embarrassed I almost cried. I mean he was so right! I was being such a fat disgusting pig, and I ruined our romantic night together. Instead of thinking of me as pretty and skinny, now I know he thinks I'm a gross fatso who can't stop stuffing her face.

PAUSE

I just feel so gross. I mean, every time I go out with a new guy I'm scared to hook up with him. I won't even have sex with Mike with the lights on, and I hate it when he touches my stomach or my thighs. I feel like they're so big and disgusting, and I worry that he's going to see the cellulite on my butt. It makes me so embarrassed.... You know, I secretly hate going shopping, too, especially when the stores have bright lights in the dressing room like Express. No matter what I try on, I never look the way I want. My best friend is so skinny, and I always feel like I'm competing with her or something. I feel so self-conscious when I go shopping with her, like everyone else in the store is thinking how fat I am compared to her, you know?

PAUSE

I'm just so sick and tired of working so hard trying to look decent and feel okay about myself. I mean, I work out every day; I watch what I eat all the time. I've tried every diet from Atkins to South Beach. But still, when I look in the mirror, I see everything that's wrong with me, and I can't help but feel like a big fat failure. How come no matter how hard I work I can't look the way I want? You know, I even made

myself throw up once or twice when I felt like I'd eaten way too much, but it freaked me out. I don't want to become one of those anorexic girls or anything.... I mean, I knew this girl in high school who was anorexic, and she was really sick. But sometimes, I secretly felt a little jealous of her, because at least she was skinny.

PAUSE

I guess what I really want to know is how am I supposed to fix this thing with Mike? I'm scared to call him because after he dropped me off last night, I was feeling so depressed and disgusting that I said fuck it and finished off a pint of Ben and Jerry's. I'm feeling so bloated today, I don't want him to see me like this. You know, it was so hard for me to feel comfortable with him in the first place, and now I feel so awkward around him again. He can't possibly like me anymore after seeing the real me. I feel like some huge cow or something when I'm with him now. There's no way he could still like me.

PAUSE

(End of Script)

Appendix E:

Warm-up State Anxiety Inventory (Warm-up SAI)

A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate letter to the right of the statement to indicate how you felt overall during your session with Sarah (the first client). There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your feelings during the session best.

Respond only to how you felt during your session with Sarah **the first client**

N = not at all		S = somewhat	M = moderately so	V = very much	
1.	I felt calm.....	N	S	M	V
2.	I felt secure.....	N	S	M	V
3.	I was tense.....	N	S	M	V
4.	I felt strained.....	N	S	M	V
5.	I felt at ease.....	N	S	M	V
6.	I felt upset.....	N	S	M	V
7.	I was worrying over possible misfortunes.....	N	S	M	V
8.	I felt satisfied.....	N	S	M	V
9.	I felt frightened.....	N	S	M	V
10.	I felt comfortable.....	N	S	M	V
11.	I felt self-confident.....	N	S	M	V
12.	I felt nervous.....	N	S	M	V
13.	I was jittery.....	N	S	M	V
14.	I felt indecisive.....	N	S	M	V
15.	I was relaxed.....	N	S	M	V
16.	I felt content.....	N	S	M	V
17.	I was worried.....	N	S	M	V
18.	I felt confused.....	N	S	M	V
19.	I felt steady.....	N	S	M	V
20.	I felt pleasant.....	N	S	M	V

Stimulus State Anxiety Inventory (Stimulus SAI)

A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate letter to the right of the statement to indicate how you felt overall during your session with Margaret (the second client). There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your feelings during the session best.

Respond only to how you felt during your session with Margaret ****the second client****

N = not at all		S = somewhat	M = moderately so	V = very much		
1.	I felt calm.....	N	S	M	V	
2.	I felt secure.....	N	S	M	V	
3.	I was tense.....	N	S	M	V	
4.	I felt strained.....	N	S	M	V	
5.	I felt at ease.....	N	S	M	V	
6.	I felt upset.....	N	S	M	V	
7.	I was worrying over possible misfortunes.....	N	S	M	V	
8.	I felt satisfied.....	N	S	M	V	
9.	I felt frightened.....	N	S	M	V	
10.	I felt comfortable.....	N	S	M	V	
11.	I felt self-confident.....	N	S	M	V	
12.	I felt nervous.....	N	S	M	V	
13.	I was jittery.....	N	S	M	V	
14.	I felt indecisive.....	N	S	M	V	
15.	I was relaxed.....	N	S	M	V	
16.	I felt content.....	N	S	M	V	
17.	I was worried.....	N	S	M	V	
18.	I felt confused.....	N	S	M	V	
19.	I felt steady.....	N	S	M	V	
20.	I felt pleasant.....	N	S	M	V	

Appendix F:

Warm-up Client Cognitive Recall Measure

Please answer the following question regarding the first client (Sarah) by filling in the blank to the best of your knowledge:

Approximately how many words conveying specific sadness (e.g., words such as down, bad, or depressed) did Sarah use in your session?

Stimulus Client Cognitive Recall Measure

Please answer the following question regarding the second client (Margaret) by filling in the blank to the best of your knowledge:

Approximately how many words related to body, weight, or appearance (e.g., words such as ass, slim, or repulsive) did Margaret use in your session?

Appendix G:

Response Mode Categories

Approach Responses:

- 1) Approval:
 - a. Therapist appropriately sanctions, accepts, or supports the client's feelings or behaviors; and/or
 - b. Therapist expresses explicit agreement with the client's feelings or behaviors when there is sufficient evidence for such agreement.
- 2) Exploration:
 - a. Therapist asks for further clarification, elaboration, and detailing of the client's feelings or behaviors; and/or
 - b. Therapist makes suggestions that seem to fit well with the client's material.
- 3) Reflection:
 - a. Therapist repeats or restates the client's feelings;
 - b. Therapist accurately relabels the client's feelings, attitudes, or behaviors; and/or
 - c. Therapist reflects content when only content is given.
- 4) Labeling / Interpretation:
 - a. Therapist points out patterns in the client's feelings or behaviors;
 - b. Therapist suggests relationships between present feelings or behavior and past experiences; and/or
 - c. Therapist suggests underlying causes of feelings or behavior.

Avoidance Responses:

- 5) Disapproval:

- a. Therapist is critical of the client's feelings or behaviors. Even if the statement is phrased supportively, anything that negates or opposes the client's feelings is disapproval.
- 6) Silence:
 - a. Therapist says nothing for a whole speaking turn.
- 7) Ignoring:
 - a. Therapist responds to the content of the client's material but ignores the affect; and/or
 - b. Therapist seems to miss the point the client is expressing and instead comes from the therapist's own agenda or needs.
- 8) Mislabeling:
 - a. Therapist inaccurately identifies the client's feelings, attitudes, or behaviors; and/or
 - b. Therapist inaccurately identifies the degree of feelings.
- 9) Topic Transition:
 - a. Therapist changes the focus of discussion to an irrelevant topic or simply to a different topic.
- 10) Other:
 - a. Therapist's response does not fit any of the other categories. Try to absolutely rule out the other possibilities before choosing this category.

Script for Behavioral Response Coding Training Session

1. We are essentially interested in splitting up the responses into either approach or avoidance. Look at your Response Mode Categories sheet. As you can see, categories 1-4 are approach, and categories 5-10 are avoidance. Research has shown that when therapists avoid client material, it is indicative of countertransference issues going on with the therapist. Let's read over the different categories that we're talking about to get more familiar with them. (Read through each category.)
2. When we talk about approach responses, we are looking for responses that are "mostly accurate." These responses should be appropriate from a particular theory (e.g., behavioral, humanistic, psychodynamic). Please try to partial out your own theoretical bias since the responses will be coming from a wide range of backgrounds, programs, and theories.
3. Before you begin rating the units within each turn, make sure to read the *entire* turn. For instance, if there are 5 units within the first speaking turn (R1), make sure to read all 5 units before beginning to rate the first one. The idea is to listen to the music rather than the individual notes. Also, most ambiguous responses are much easier to code in the context of the entire unit.
4. Please do not spend time debating between categories within approach or avoidance. In other words, if you are torn between choosing one of two approach responses for an individual unit, just choose one without much debate. It is very tempting to think too much about this! However, the distinction between the two general categories of approach vs. avoidance is all that matters in the end.

5. We're going to read over the background information about the client given to the therapists prior to seeing the client so you know what the therapists already knew about the client and her life. (Read background information.) In addition to this background information, therapists were also asked to assume that they had already had four previous sessions with the client. Thus, therapists may make explicit reference to or suggestions based on the background information or the four assumed previous sessions. If there is evidence that the reference or suggestion is related to the assumed previous sessions or background information, it would probably be coded as 2 (exploration). If a suggestion or reference seems to come out of left field and doesn't seem to fit the flow of the material, however, it might be coded as 5 (disapproval) or 7 (ignoring).
6. Make sure to read the client's speaking turn that corresponds to the therapist's speaking turn prior to coding. For example, the client's first speaking turn contains a lot of sadness, frustration, and self-deprecation. If the therapist doesn't acknowledge this frustration in some way during her speaking turn, at least one therapist response would be coded as 7 (ignoring) since they are ignoring affect. Additionally, the degree of the reflection of feeling is important.
7. It's important to note that 5 (disapproval) can be very subtle. Wording/ phrasing of the therapist's response can make the difference between an approach response vs. this avoidance response.
8. Finally, it's important to note that the analogue situation was artificial and the therapists may have been nervous about being audiotaped, so remember that bad responses don't necessarily equal avoidance or countertransference. For example, let's

look at example 3.1. Though the responses are not great, they are still not avoidant.

Approach doesn't have to mean "good"- just somewhat accurate.

Appendix H:

Script for Interacting with Participants

1. Before handing out the initial questionnaires:

Before you watch and interact with the videotapes clients, here are some questionnaires for you to fill out. It should take a little while to get through these, but all the rest of the questionnaires in the study are much shorter. Let me know when you're finished.

2. After the participant is done with the initial questionnaires:

The following portion of the study involves your interaction with two videotape clients in two separate sessions of therapy. Please try to assume that these simulated clients are real, as is your relationship with them. So you should interact in these two therapy sessions as you would with actual clients. To help make your interaction with these clients as realistic as possible, you will be given a brief case summary before seeing each client that includes some background information about them. Also, assume you and the respective client have already established a good therapeutic relationship and that you've had four previous sessions with them. So basically, I'm going to give you the case summary for the first client, you'll watch the video of that client, then you'll fill out some very short forms, and then do it again for the second client. Your responses to these clients will be audiotaped; however, please be assured that your tape will be kept in a secure facility, your tape will be transcribed by a research assistant who does not know you and therefore will not recognize your voice, and your responses will be seen only as anonymous.

3. After handing the participant the warm-up client case summary:

Here is a case summary for the first client. When you're done reading it over, let me know, and I'll start the video.

4. After the participant gives back the warm-up client case summary:

The video has a number of pauses that will last approximately 30 seconds each. At each pause, you'll be asked to respond to the client as though you were in a normal therapy session. There will be instructions on the screen letting you know when you should start responding. When you are finished with this first client, you will fill out some brief questionnaires, then I'll give you the case summary for a second client, and the procedure will be repeated.

Please remember that there are no correct responses to the clients. You may want to respond to the clients other than when the videotape is paused, but we are only interested in your verbal responses to the clients at the pre-established pause points. As I mentioned before, your identity is in no way going to be associated with your responses. If you have any questions, please ask them now.

5. After the warm-up video is over:

Here are some brief questionnaires that ask you about your experience with this first client. Let me know when you're finished with them, and I'll give you the case summary for the second client.

6. After the participant is finished with the questionnaires:

Here is a case summary for the first client. When you're done reading it over, let me know, and I'll start the second video.

7. After the stimulus video is over:

Here are some brief questionnaires that ask you about your experience with the second client. Note that this time there are four measures as opposed to two. Please make sure you complete all of them, and let me know when you're finished.

8. After the participant is finished with the questionnaires:

Thank you for participating in this study. Here is a debriefing form that explains the purpose of the study. Please do not discuss this study with anyone as many therapists have not yet participated. Do you have any questions?

Appendix I:

Informed Consent Form

Project title: Psychotherapy Relationship Study

Investigators:

Elizabeth E. Doschek, UMD, College Park, 301-580-8014, edoschek@psyc.umd.edu

Dr. Charles J. Gelso, UMD, College Park, 301-405-5909, gelso@psyc.umd.edu

Statement of age of subject: I state that I am over 18 years of age and wish to participate in a program of research being conducted by Elizabeth E. Doschek in the Department of Psychology at the University of Maryland, College Park.

Purpose of study: This study is designed to investigate the psychotherapy process in the fifth session of counseling.

Procedures: I am aware that I will be asked to participate today in two simulated counseling sessions with videotaped clients, after which I will be asked questions about myself and my perception of the sessions. I am also aware that I will be asked to complete several brief questionnaires prior to the sessions. I am aware that my participation in this study will require a single 60-minute time commitment.

Confidentiality: I am aware that all information collected in the study is confidential, and that I will not be identified by name at any time. The research questionnaires will contain as the only identifier a randomly assigned code. All questionnaires will be kept in a secure facility.

Risks: I am aware that there are no known risks to my participation in this research.

Benefits, freedom to withdraw, and ability to ask questions: Although participation in this study is not designed to benefit me personally, the investigators hope that this study will provide insight into the psychotherapy process so that better programs to help counselors develop effective techniques and skills will be implemented. In addition, completing the questionnaires will allow me to reflect on my development as a counselor to this point. I am free to ask questions or withdraw from participation at any time and without penalty.

Printed Name _____ Signature _____ Date _____

If you have questions about your rights as a research subject or wish to report a research-related injury, please contact: **Institutional Review Board Office, University of Maryland, College Park, Maryland, 20742; e-mail: irb@deans.umd.edu; telephone: 301-405-4212.**

Please keep a copy of the consent form for your records.

Appendix J:

Manipulation Check

Please rate the second client's (Margaret's) physique by circling your answer to the below question after reading the following instructions:

INSTRUCTIONS: Body Mass Index (BMI) is a modified weight to height ratio used by public health officials and physicians to determine if a person is underweight, normal weight, overweight, or obese. The following are the Centers for Disease Control and Prevention (CDC) guidelines for interpreting BMI scores:

BMI	Weight Status
Below 18.5	Underweight
18.5 – 24.9	Normal
25.0 – 29.9	Overweight
30.0 and Above	Obese

The second client (Margaret) is within the normal BMI range (i.e., her BMI is between 18.5 and 24.9). Margaret is not underweight, overweight, or obese. Please rate where **within the normal BMI range** you believe Margaret falls. Remember that by marking 7, you are not indicating that you believe Margaret to be overweight. Rather, you are indicating that you believe Margaret to be at the high end of the normal BMI range. Similarly, by marking 1, you are not indicating that you believe Margaret to be underweight. Rather, you are indicating that you believe Margaret to be at the low end of the normal BMI range. Please try not to be “politically correct” in your rating of Margaret’s BMI. If you believe Margaret to be at the high end of the normal BMI range, do not be reluctant to rate her physique a 7. Remember, by rating her physique a 7, you are not indicating that you believe her to be overweight. Similarly, if you believe Margaret to be at the low end of the normal BMI range, do not be reluctant to rate her

physique a 1. Remember, by rating her physique a 1, you are not indicating that you believe her to be underweight.

How would you rate Margaret's physique **within the normal BMI range**?

1 normal/light BMI = 18.5	2	3	4 normal/moderate BMI = 21.7	5	6	7 normal/heavy BMI = 24.9
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Appendix K:

Demographic Form

Age: _____

Race/Ethnicity (please circle):

African-American

Latina

Asian-American

Native American

European American (White)

Other (please identify): _____

Sexual Orientation (please circle):

Heterosexual

Lesbian

Bisexual

Other (please identify): _____

Highest degree held (e.g., BS, LCSW, MA in Counseling, Ph.D., etc.) _____

Year in current graduate program: _____

Type of current graduate program (e.g., Masters in Counseling, Ph.D. in Clinical Psychology, etc.):

Using a 5-point scale, where 5 = very high belief, rate how much you believe in and adhere to the techniques of:

_____ Psychoanalytic/Psychodynamic Therapy

_____ Experiential/Humanistic/Existential Therapy

_____ Behavioral/Cognitive Behavioral Therapy

Please write in your theoretical orientation: _____

Approximate Total Number of Supervised Clients Seen: _____

Approximate Number of Supervised Face-to-Face Client Hours Thus Far: _____Approximate Total Number of Supervised *women* Clients Seen: _____Approximate Number of Supervised Face-to-Face *women* Client Hours Thus Far: _____

Appendix L:

Debriefing Form

Thank you for participating in this study. The purpose of the study is to investigate women therapists' reactions to women clients with body image concerns. You have participated in one of two conditions. In one condition, the physique of the client with body image concerns whom you saw is close to the societal ideal. In the second condition, the physique of the client is far from the societal ideal. Before seeing this client, you completed a questionnaire measuring your own body image concerns. This questionnaire along with your verbal responses and the two measures you completed after seeing the client will be used to see if client physique and women therapists' body image concerns are related to their reactions toward women clients with body image concerns.

Please know that your verbal responses to the videos and written responses to the questionnaires will be held in strict confidentiality, and your responses will only be seen as anonymous. Many therapists have not yet participated in this study; thus, we must ask you not to discuss this study in detail with anyone. This is essential to maintaining the study's validity. If you have any questions or concerns, please feel free to contact Elizabeth Doschek, the study's primary investigator, at (301) 580-8014. Again, thank you for your participation.

Appendix M:

Table 1Participant Demographics Descriptive Statistics

<u>Variable</u>	<u>Central Tendency</u>		<u>Variability</u>		
	Mean	Median	SD	Range	Possible Range
Age	26.89	25.00	5.69	21-47	N/A
Year in Program	3.00	2.00	1.28	1-6	N/A
PT	2.44	2.00	1.33	0-5	0-5
E/HT	3.62	4.00	1.04	1-5	0-5
CBT	3.37	4.00	1.24	1-5	0-5
NC	30.80	15.00	55.14	1-300	N/A
CH	204.12	82.50	306.13	1-1200	N/A
NWC	23.29	8.50	49.73	1-280	N/A
WCH	126.21	50.00	220.74	1-950	N/A

PT = Psychoanalytic/Psychodynamic Therapy; E/HT = Experiential/Humanistic/Existential Therapy; CBT = Behavioral/Cognitive Behavioral Therapy; NC = Number of Supervised Clients Seen; CH = Number of Supervised Client Hours; NWC = Number of Supervised Women Clients Seen; WCH = Number of Supervised Women Client Hours

Table 2Participant Demographics Descriptive Statistics Continued

<u>Variable</u>	<u>Frequency</u>	<u>Percent of Sample</u>
Race		
African-American	2	5.7
Asian-American	4	11.4
European American (White)	22	62.9
Latina	2	5.7
Native American	0	0
Other	5	14.3
Sexual Orientation		
Heterosexual	28	80.0
Bisexual	6	17.1
Lesbian	1	2.9
Other	0	0
Program		
Counseling Psychology PhD	13	37.1
Clinical Psychology PhD	9	25.7
School Psychology PhD	2	5.7
Social Work MA	2	5.7
Rehabilitation Counseling MA	3	8.6
College Student Personnel MA	6	17.1

Appendix N:

Table 1Actress Believability and Likeability descriptive statistics

<u>Variable</u>	<u>Central Tendency</u>		<u>Variability</u>		
	Mean	Median	SD	Range	Possible Range
Believability					
Ideal-close 1	4.00	4.50	1.26	2-5	1-5
Ideal-close 2	4.58	4.75	.49	4-5	1-5
Ideal-far 1	3.67	4.00	1.03	2-5	1-5
Ideal-far 2	3.33	3.00	1.37	2-5	1-5
Likeability					
Ideal-close 1	3.33	3.50	.83	2-4	1-5
Ideal-close 2	4.17	4.00	.75	3-5	1-5
Ideal-far 1	2.50	3.00	.84	1-3	1-5
Ideal-far 2	4.33	4.00	.52	4-5	1-5

Table 2Actress Attractiveness and Attractiveness Disregarding Weight descriptive statistics

<u>Variable</u>	<u>Central Tendency</u>		<u>Variability</u>		
	Mean	Median	SD	Range	Possible Range
Attractiveness					
Ideal-close 1	3.50	3.50	.55	3-4	1-5
Ideal-close 2	4.00	4.00	.63	3-5	1-5
Ideal-far 1	2.67	2.50	.82	2-4	1-5
Ideal-far 2	3.67	4.00	.52	3-4	1-5
Attractiveness disregarding weight					
Ideal-close 1	3.50	3.50	.55	3-4	1-5
Ideal-close 2	4.00	4.00	.63	3-5	1-5
Ideal-far 1	3.00	3.00	1.10	2-4	1-5
Ideal-far 2	3.83	4.00	.41	3-4	1-5

Appendix O:

Table 1

Means and Standard Deviations for Dependent Variables by Client Physique Category
(Ideal-close or Ideal-far) and Actress

<u>Physique</u>	<u>State Anx.</u>		<u>Cog. Recall</u>		<u>Turn Avoid.</u>	
	Mean	SD	Mean	SD	Mean	SD
Ideal-close	36.88	8.82	18.44	6.28	17.65	26.50
Actress 1	35.78	9.51	19.06	4.80	16.67	26.96
Actress 2	38.13	8.44	17.75	7.92	18.75	27.78
Ideal-far	41.94	11.17	18.67	8.81	14.68	17.23
Actress 1	39.00	12.53	16.83	7.73	11.11	15.20
Actress 2	44.89	9.41	20.50	9.89	18.25	19.27

State Anx. = Stimulus State Anxiety Inventory; Cog. Recall = Average Cognitive Recall;

Turn Avoid. = Speaking Turn Avoidance

Table 2

t tests of Actress Effects

<u>Actresses</u>	<u>State Anx.</u>	<u>Cog. Recall</u>	<u>Turn Avoid.</u>
Ideal-close 1 vs. Ideal-close 2	t = -.54	t = .42	t = -.16
Ideal-far 1 vs. Ideal-far 2	t = -1.13	t = -.88	t = -.87

* = $p < .10$

State Anx. = Stimulus State Anxiety Inventory; Cog. Recall = Average Cognitive Recall;

Turn Avoid. = Speaking Turn Avoidance

Appendix P:

Table 1Correlations between Therapist Theoretical Orientation and Dependent Variables

Variables	PT	E/HT	CBT	State Anx.	Cog. Recall	Turn Avoid.
PT	1	.30	-.32	.29	-.20	-.09
E/HT		1	-.51*	.16	.03	-.08
CBT			1	-.17	-.07	.31
State Anx.				1	.02	-.17
Cog. Recall					1	-.02
Turn Avoid.						1

* $p < .05$, two-tailed

PT = Psychoanalytic/Psychodynamic Therapy; E/HT = Experiential/Humanistic/Existential Therapy; CBT = Behavioral/Cognitive Behavioral Therapy; State Anx. = Stimulus State Anxiety Inventory; Cog. Recall = Average Cognitive Recall; Turn Avoid. = Speaking Turn Avoidance

Table 2

Partial correlations between Therapist Theoretical Orientation and Dependent Variables
controlling for Warm-up Anxiety

Variables	PT	E/HT	CBT	State Anx.	Cog. Recall	Turn Avoid.
PT	1	.37*	-.37*	.17	-.26	-.11
E/HT		1	-.50*	.34	.07	-.08
CBT			1	-.30	-.10	.40*
State Anx.				1	-.10	-.27
Cog. Recall					1	.10
Turn Avoid.						1

* $p < .05$, two-tailed

PT = Psychoanalytic/Psychodynamic Therapy; E/HT = Experiential/Humanistic/
 Existential Therapy; CBT = Behavioral/Cognitive Behavioral Therapy; State Anx. =
 Stimulus State Anxiety Inventory; Cog. Recall = Average Cognitive Recall; Turn
 Avoid. = Speaking Turn Avoidance

Table 3

Partial correlations between Therapist Theoretical Orientation and Dependent Variables
controlling for Number of Supervised Women Client Hours

Variables	PT	E/HT	CBT	State Anx.	Cog. Recall	Turn Avoid.
PT	1	.29	-.27	.41*	-.18	-.01
E/HT		1	-.52*	.19	.03	-.07
CBT			1	-.32	-.14	.35*
State Anx.				1	-.10	-.27
Cog. Recall					1	.10
Turn Avoid.						1

* $p < .05$, two-tailed

PT = Psychoanalytic/Psychodynamic Therapy; E/HT = Experiential/Humanistic/
 Existential Therapy; CBT = Behavioral/Cognitive Behavioral Therapy; State Anx. =
 Stimulus State Anxiety Inventory; Cog. Recall = Average Cognitive Recall; Turn
 Avoid. = Speaking Turn Avoidance

Appendix Q:

Table 1Intercorrelations between Therapist Experience and Dependent Variables

Variables	CN	CH	WCN	WCH	State Anx.	Cog. Recall	Turn Avoid.
CN	1	.78*	.99*	.92*	-.26	-.15	-.23
CH		1	.68*	.93*	-.31	-.18	-.28
WCN			1	.87*	-.25	-.11	-.21
WCH				1	-.34	-.15	-.30
State Anx.					1	.02	-.17
Cog. Recall						1	-.02
Turn Avoid.							1

* $p < .05$, two-tailed

CN = Number of Supervised Clients Seen; CH = Number of Supervised Client Hours;

WCN = Number of Supervised Women Clients Seen; WCH = Number of Supervised

Women Client Hours; State Anx. = Stimulus State Anxiety Inventory; Cog. Recall =

Average Cognitive Recall; Turn Avoid. = Speaking Turn Avoidance

Table 2

Partial correlations between Therapist Experience and Dependent Variables controlling for Warm-Up Anxiety

Variables	CN	CH	WCN	WCH	State Anx.	Cog. Recall	Turn Avoid.
CN	1	.76*	.99*	.92*	-.13	-.11	-.27
CH		1	.66*	.92*	-.18	-.14	-.28
WCN			1	.86*	-.13	-.07	-.26
WCH				1	-.22	-.11	-.30
State Anx.					1	-.10	-.27
Cog. Recall						1	.10
Turn Avoid.							1

* $p < .05$, two-tailed

CN = Number of Supervised Clients Seen; CH = Number of Supervised Client Hours;
 WCN = Number of Supervised Women Clients Seen; WCH = Number of Supervised
 Women Client Hours; State Anx. = Stimulus State Anxiety Inventory; Cog. Recall =
 Average Cognitive Recall; Turn Avoid. = Speaking Turn Avoidance

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