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An examination of social workers' and other therapists' use of transference and countertransference as therapeutic tools in couples counselling within the psychoanalytic paradigm

Heidi B. Gottlieb
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An Examination of Social Workers' and Other Therapists' Use of Transference and Countertransference as Therapeutic Tools in Couples Counselling within the Psychoanalytic Paradigm

By

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DISSERTATION
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Abstract

The purpose of this study is to increase knowledge about therapeutic practices on the part of practitioners; specifically, the study asked social workers and other types of therapists who see couples about their awareness of, acknowledgment of, attitude toward, understanding of, and use of the psychoanalytic model and of the concepts of transference and countertransference, and to demonstrate to what extent they accurately comprehend the meaning and potential use of these concepts in their clinical practice. A survey/questionnaire was mailed to a large sample of social workers and other therapists in Ontario, and provided 941 responses. An included vignette gave respondents the opportunity to put their theoretical knowledge into clinical application. Responses were assessed through scoring on key indices of awareness of, acknowledgment of, understanding of, attitude toward, and use of transference and countertransference. This study provided evidence of a deficiency in these indices and in the use of the psychoanalytic model on the part of practitioners who treat couples. Only 6.1% of these respondents selected the psychoanalytic paradigm as their first choice in treating couples. Few couples counsellors considered transference and/or countertransference as key issues in assessment. (Of these practitioners, only 7.5% gave at least one accurate example). Results from this study revealed a significant disparity between practitioners' theoretical knowledge and their practical application. A linear model was employed to identify predictors of application/use of transference and countertransference. The most important predictor was respondents' perception of the psychoanalytic model in terms of its usefulness in treating the couple presented in the vignette. The object relations model was used to help explicate the findings of this study. Implications of this study included the need for further training of practitioners in order to increase their theoretical knowledge and clinical skills concerning use of the psychoanalytic paradigm and of the concepts of transference and countertransference.

Acknowledgments

The theme of this research study is that of "the dance" that partners do with each other on both a conscious and an unconscious level, and the focus of this study has been on the psychoanalytic paradigm and the concepts of transference and countertransference that may be used as efficacious therapeutic tools to assist therapists as they seek to help troubled couples connect with each other in a healthier and happier way.

My own life reflects that of the theme of this dissertation, in that I have also been engaged in a dance, and I have been very blessed to have had many partners sharing this dance with me along the way. It is said that people come into our lives for various reasons, and that our relationships are a gift to be cherished. When we know how to care for our partners and how to appreciate our partners, then we are given the gift of this blessing. Some partners come into our life for a short time, and others stay forever.

First and foremost, I would like to thank my dissertation committee for being an outstanding team. Each member of our team individually has been an integral and invaluable participant in this learning process and in our doctoral dance, and collectively they have worked together impressively. Without their help and ongoing support, this dissertation could not have been written.

To my dean and committee member, Luke Fusco, thank you for always being a source of inspiration, support, and guidance. I am very grateful. Thank you also for opening the door to psychoanalytic theory for me, and for sharing your pearls of wisdom with me concerning the use of transference and countertransference as efficacious therapeutic tools. I well remember how the topic for this research study grew out of our psychoanalytically oriented discussions, and I am grateful for that.

To Dr. Carol Stalker, thank you for being so vigilant in our project. I appreciate the time, effort, interest, and enthusiasm that you put into this dissertation to make it the polished version

that it finally is. You have been a positive role model for me throughout this process, and you have taught me a great deal about being a committed academic, an adept researcher, and a committed practitioner. I have learned much from you during the course of the doctoral dissertation dance in many ways. I am grateful for all that you have done to help make this dissertation a more polished one.

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My dancing partner in love and in life, Abraham (Avi) Sklar, from what seems a lifetime ago, taught me what it means to be a true partner and what it means to have a happy and fulfilling marriage. We danced together for a while, and for our beautiful time together I will forever be grateful. I am glad that I had the opportunity to help you accomplish your dreams, and I am grateful to you for supporting me in mine. Thank you for always believing in me, and for telling me that I can accomplish anything if I really want to. Thank you for asking me to dance with you through life all those years ago, and for giving me the chance to experience in practice all that I had learned concerning the creation and maintenance of a mutually happy, healthy, loving, and fulfilling, committed romantic relationship. I am very appreciative of all that you are, and all that we had together.

To my dear and much beloved parents, I am truly indebted. My parents have always been and continue to be wonderful role models to me, as loving and devoted mates and as loving and devoted parents. My parents continually teach me about true love, caring, and commitment, and about how important it is to "be there" for others and to help other people. My mother and father

continually believe in me, and for that I am grateful. They are proud of me, just because I am who I am, and for that I am very grateful as well. My mother and father have always been supportive of me and of my dreams, and no matter what I have taken on, they always join the dance and happily dance with me.

Although I have already expressed my gratitude to my parents, I am extending a very special thank-you to my much cherished mother, who loves me unconditionally and who has made my dreams and my happiness her own. Mom, thank you so much for your love, support, guidance, and encouragement. It is because of you that I became a social worker who loves helping others, and it is because of you that I continued to do the doctoral dance even at the most difficult of times. You deserve recognition, and you have my constant admiration.

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this even before I did. Working on this major project has been an incredible experience, and both a wonderful and a challenging dance. I am grateful to you for dancing with me during this time, and for wanting to be my partner so that we could share this dance together. I do not know how I can thank you completely, but I hope that you know how much I appreciate you and all that you have done. Perhaps this is a good start. I wish you happiness and success in the fulfilment of your dreams as you continue on your own journey, and begin to do your own dance.

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This doctoral journey has taken me to great heights, expanded my mind and heart further than I ever thought they were capable of going, and taught me much about persistence, patience, and diligence. I have learned much, and I have been able to integrate new dance steps into my life professionally and personally, while still being able to do my own. For all that I have learned, for all that I have accomplished, for all that I now have and will go on to teach, give to, and share with others, I am very grateful. For all of those people who have supported, facilitated, and joined my doctoral dance in their own unique way and enhanced this experience, I am very grateful, too.

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An Important Note for the Reader
from the Researcher

The present reality in our society is that many individuals today are involved as partners within committed, romantic, and intimate relationships outside of the legal and/or religious conditions that would render the relationship a "marriage". Additionally, there is a large and growing number of individuals in interaction within these couple systems. As a result of these present realities and growing trends, this researcher refers to "couples" within this research study to describe this specific interpersonal unit; the terms "dyad" or "couple system" are also used throughout this study interchangeably.

The terms "marriage" and "marital" may be used, especially when these terms are used by the various authors and/or researchers whose work is cited in this research study. The reader is asked to consider the concepts of "marriage" and "being a couple", as well as "marital counselling/ therapy" and "couple counselling/therapy" as interchangeable, for purposes of this study. This researcher will be using the terms "partner", "romantic partner", "mate", "spouse" and "marital mate", as well as "significant other" interchangeably. For purposes of this research study, the reader is asked to consider all of these terms equal in their meaning and in their overall relevance.

Presently, there is a relatively high proportion of individuals who are involved in couple relationships, and the unique characteristics, needs, desires, hopes, dreams, pleasures, disappointments, frustrations, disillusionment, concerns, difficulties, issues, crises, resolutions, and joys of these partners, as individuals and as two mates in interaction as a couple, are very similar to, and shared by the marital, common law, and couple units. All of these couple systems consist of two individuals, attempting to act and interact as partners within their dyadic relationship, whether functionally or dysfunctionally. Our role, as clinicians, researchers, and educators, is to not only enhance our own understanding of dyadic dynamics and the functioning of couple systems, but to also help the dyadic partners to better understand themselves, each other,

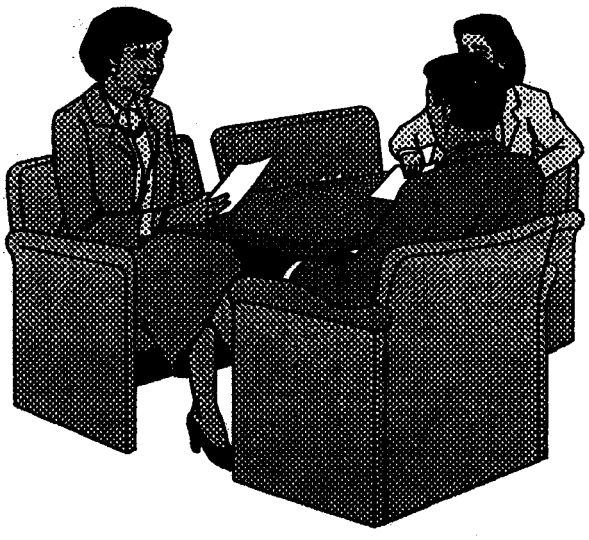
and their relationship, in order for them to relate better, not as two self-focused individuals in constant conflict, but as two partners who are conscious of and sensitive to both "self" and "self-in-relation-to-other", and who are committed to acting and interacting functionally and in harmony as one dyad called "a couple".

From romance and courtship:

"There is only one happiness in life...
To love and to be loved."
(George Sands, pseudonym of Amandine-Aurore-Lucile Dudevant,
French Romantic writer. 1804 - 1876.)

From romance to reality:

"They dream in courtship, but in wedlock wake."
(Alexander Pope: The Wife of Bath's Prologue)
(Pope as cited in Andrews, Biggs, & Seidel, 1996).

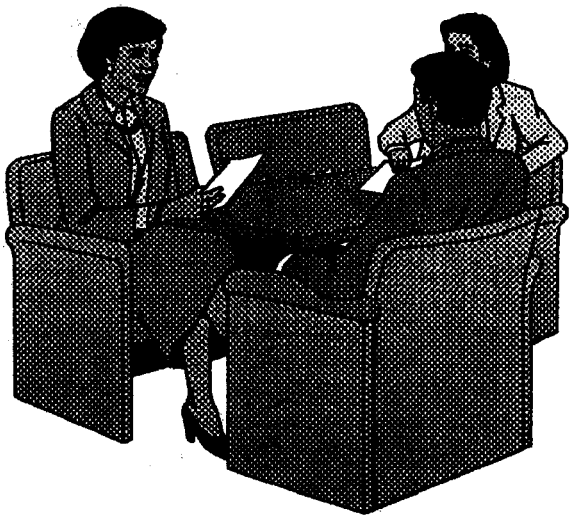


The Dyadic Dance done by Couples:

"I don't know why we go over the old hurts
Again and again in our minds, the false starts
and true beginnings
As if it could tell us of a world we call the past
who we are now,
Or were, or might have been."
(Hirsch, 1989, in Kershaw, 1992, p. 222).

The Dyadic Dance becomes Triadic and Therapeutic as the Therapist Joins in Couples Counselling:

"To stay within a framework of operating belief systems, it is important to join the ritualistic and familiar dance of the couple before intervening. The therapist must join the system and utilize the symptom to help create change."
(Kershaw, 1992, p. 76).



Part 1:

Chapter 1

Introduction

The motivation for, creation of, and maintenance involved in a mutually caring, loving, and respectful, romantic relationship that is both fulfilling and functional for both partners has been and continues to be a critical question for both couples and couples therapists, as well as for researchers in this area. The growth and development of the romantic relationship, as well as the unravelling and destruction of the dyadic unit referred to as the couple system, have been and continue to be important issues for concern, exploration, understanding, and reparation. What is the motivation that propels individuals to seek each other as dyadic partners, and what are the elements that impact upon their relationship on both a conscious and an unconscious level? Are the motivating forces that propel individuals to seek and find each other the same forces that contribute to push partners apart?

When a couple is in crisis, one of the essential elements that can facilitate change and move the couple toward resolution is an understanding of themselves and each other, as individuals and as partners in dyadic interaction, as well as insight into how and why they interact in the way that they do, whether functionally or dysfunctionally. How do individual partners come to attain a mutual understanding of themselves, each other, and their relationship? How can couples counsellors help couples to achieve this understanding, as individual partners and as a dyadic system in interaction? Which theoretical model is useful in guiding practitioners as they seek to promote understanding and intervention, and which concepts may be used as therapeutic tools to accomplish this requisite process of uncovering and discovering within the therapeutic process before helping partners to recover and heal?

The psychoanalytic paradigm can be useful as a model of understanding within which to gain insight, and also highly effective as a model of intervention with which to improve and facilitate

functioning. Within the therapeutic setting, there is an opportunity for the couples therapist to observe the "dyadic dance" that the partners do with each other, for each other, and to each other on many levels. There is also an opportunity for the couples therapist to join the dyadic dance that becomes triadic as the therapist plays the role of both observer and participant within the system to effect the necessary change. The dance steps that have been learned and integrated from childhood, and which are now being repeated by partners within their own romantic relationship as adults, need to be examined and the roots of the dysfunctional dance steps need to be revealed, understood, and changed. The newer, healthier dance steps toward functional modes of relating need to then be learned, practised, and well-integrated on both an intrapsychic and interpsychic level by both partners. This intricate process requires a theoretical model that focuses on the intrapersonal and interpersonal dynamics, the past as an explanation of the present, and the present as a foundation on which to develop a healthier future. Potent therapeutic tools are also required for this intensive process of uncovering, discovering, and recovering to occur.

The complex couple system, which is comprised of two individual partners with two distinct selves in constant interaction intrapsychically and interpsychically, is a challenging case for the therapist who is clinically confronted with it. The unique nature and characteristics of the dyadic client system demand a very special and unique approach. The psychoanalytic paradigm with its focus on the self and on the self-in-relation-to-other, as well as its ability to transcend the difficulties of the present through a resurrection of the past and a healthier re-creation in the present, offers both the client/client couple and the therapist who is engaged in couples counselling, an opportunity for therapeutic discovery and rediscovery, new hope, and the potential for and experience of positive/functional change. This is an emotional re-experiencing process on both a conscious and an unconscious level, and an invaluable opportunity, which the couple would not be able to have anywhere else. Additionally, it is the psychoanalytic paradigm that offers the therapist the concepts of transference and countertransference, natural phenomena that can be viewed and used as therapeutic tools, efficacious in their ability to facilitate the

exploration, revelation, and reparation process from the past into the present, and which can lead to healthier and happier functioning for the couple. The healthier functioning that can result manifests itself for each partner as an individual intrapsychically and also for the mates as a dyadic system in which they are in constant interaction interpsychically.

Focus of this Study:

The focus of this research study is the extent to which there is an awareness of, an acknowledgment of, a theoretical and clinical identification of, attitude toward, understanding of, and an appropriate use of transference and countertransference in clinical practice on the part of social work therapists and other types of therapists, when working with couples within the psychoanalytic paradigm.

This problem is significant to study for several reasons. Recent research studies have produced jarring statistics that reveal that the rate of dyadic breakdown for partners (whether within a marital or common law unit, or within a romantic relationship outside of these two units/classifications), is on the increase. The rate of marital/couple discord and consequent breakdown is increasing, and the divorce rate/breakup rate for couples is escalating. This phenomenon has devastating consequences, not only for the dyadic unit, but also for the individual partners who form that unit, as well as for any child(ren) who may be a product of this union. At a time when the structure and the very existence of the nuclear family are in question and in jeopardy, the escalating rate of dyadic breakdown and consequent breakup is cause for serious concern. The fear, hesitation, and doubt that have become prevalent concerning entry into a marital union are also evident; it appears that there are few guidelines and few guarantees to having a mutually fulfilling and successful long-term dyadic relationship. Clearly, something is not working, or it is not working well.

Historically, the family has always been the foundation for society and societal structure, and the marital unit shared by both partners has been viewed as the cornerstone of this foundation.

When the cornerstone crumbles, the firm foundation becomes shaky and questionable, and this has serious implications for the couple and the family system at the micro level, for the extended community at the macro level, and for the larger society and the institutional organizations at the mezzo level. Both the detrimental consequences and the distress for couples and therapists are extensive.

If the need and the demand for counselling from both individuals and couples increase as these client systems turn to social work practitioners and other therapists for answers, guidance, and help, are practitioners adequately and appropriately prepared with the treatment model, therapeutic technique, and tools necessary to meet these realistic needs?

This research study will increase knowledge about the proportion of social workers and/or other types of therapists who are aware of, acknowledge, and use the concepts of transference and countertransference in their work with couples, and it will also demonstrate the extent to which these practitioners accurately comprehend the meaning and potential use of these concepts in their practice. Therapists need to be both informed about and attentive to these concepts in order for them to determine how to apply these concepts in their work with couples. Increased awareness of theoretical concepts that can be viewed and employed in clinical practice as therapeutic tools to (1) help both therapist and client/client couple in the pivotal process of uncovering and discovering latent origins of dysfunction, and to (2) promote healthier and happier functioning, would clearly be a welcome addition to both the theoretical and the clinical realms of social work practice.

The premise of therapy based on psychoanalytic theory is that the emotional experience of the past through a re-creation in the present is potentially curative. The psychoanalytic theoretical framework is unique in its ability to guide the therapist in his/her efforts to create the therapeutic setting requisite for this re-dramatization to occur, and literally, to provide a safe and secure arena, an experienced and caring facilitator, and the opportunity for the old drama to be played out again, but with the hope and realistic expectation of a happier ending. Since the setting,

facilitator, and opportunity for change are present, the appropriate technique and correct tools to effect the desired change and the happier outcome are also required.

This researcher proposed that the concepts of transference and countertransference, and associated therapeutic techniques were not being used to the extent that they could be in current clinical practice. She suspected that there was a lack of awareness and/or a lack of acknowledgment of these phenomena on the part of the therapists who work with couples. Additionally, the critical question to consider in relation to those therapists who are aware of the existence of these therapeutic phenomena that may be used in therapy is: Are they using this awareness accurately, and therefore applying these therapeutic tools properly? There are related critical questions to consider as well. To what extent are social work practitioners who treat couples, and other marital/couples therapists, aware of transference and countertransference? How accurate is their understanding? These essential questions have been posed and answered through this exploratory research study; this research study will provide increased knowledge about the degree to which transference and countertransference are being used in the treatment of couples, and it will also give some indication of the depth of understanding that therapists have of these concepts, which may be viewed and used as efficacious therapeutic tools.

It is significant to note that many of the clinical objectives for effective couples counselling may be accomplished through the conscious and competent use of transference and countertransference. It is this researcher's contention that the conscious and competent use of transference and countertransference is key to the appropriate application of psychoanalytic theory to work with couples. These concepts are critical keys to provide insight, understanding, and corrective change to couples on both an individual and a dyadic level. The awareness of, acknowledgment of, understanding of, attitude toward, and use of these therapeutic tools by therapists in working with couples is the focus of this research.

Background of the Problem:

Most of the literature published in the area of couples counselling does not adopt the psychoanalytic perspective as a model of understanding and intervention; furthermore, the research studies that have been done to demonstrate the effectiveness of couples counselling within the psychoanalytic paradigm do not address or investigate transference and countertransference as potentially integral components. The few research studies that have examined transference and countertransference are in the context of treatment of individuals, not couples. It is also significant to note that most research studies that focus on the application of the psychoanalytic paradigm (which includes insight-oriented therapy or emotionally focused therapy since both of these are classified as psychoanalytic/psychodynamic models) to couples therapy, are outcome studies. The few studies that examine process do not make any reference to transference and countertransference as therapeutic tools that may be used effectively in working with couples. (These research studies will be summarized in detail in Chapter 2, Review of the Literature).

Rationale:

As previously stated, there are few research studies that examine the application of the psychoanalytic model to couples counselling. Additionally, these studies do *not* mention transference and countertransference. The few psychoanalytic studies that do exist, focus on the treatment of individuals. There is a paucity of research studies that *do* focus on transference and countertransference, but these studies are in the context of counselling individuals, not couples. There is definitely a gap in the research and in the field, which was the rationale for this research study. This research study was proposed and then designed to help fill this gap.

Since this research study is an exploratory study, several research questions were considered. The overarching research questions were: How do therapists (1) perceive, and (2) use transference and countertransference in couples counselling within the psychoanalytic paradigm?

Specifically, do social work therapists who treat couples have an awareness of transference and countertransference? Are there differences between social workers and non-social workers who are therapists? Do therapists acknowledge these concepts in their clinical practice, and how does this awareness translate into practical application in the treatment of couples within the clinical realm?

A survey/questionnaire was mailed to social work practitioners and other non-social work therapists classified as "other therapists", along with a (case) vignette. The questionnaire initially asked for basic demographic data and then sought general information related to how practitioners practise in the clinical realm; further along it asked the respondent to refer to and read the enclosed vignette, and then to answer the remaining questions on the questionnaire that corresponded to this vignette. The instrument (i.e. survey/questionnaire) was designed to demonstrate therapists' awareness of, acknowledgment of, and identification of the concepts of transference and countertransference. As well, the questions that corresponded to the vignette were designed to demonstrate, through therapists' responses, whether or not therapists have an accurate understanding of these concepts, and whether or not they are able to apply these concepts appropriately as therapeutic tools in working with/treating couples.

Briefly, this research study was designed to investigate what proportion of couples therapists use a psychoanalytic model in treating couples in general, and among those who do, to what degree they accurately demonstrate their understanding of this model by stating its key tenets. This research study also investigated to what extent a respondent demonstrated an accurate understanding of the psychoanalytic theoretical orientation when he/she chose and identified this model as the model that he/she believed to be the best one in the treatment of couples in general, and in treating the client/client couple in the vignette. In summary, how does the therapist's own knowledge, awareness, and understanding help or hinder him/her as he/she strives to provide the client/client couple with insight, meaning, and improved relational functioning requisite to the

corrective therapeutic experience? How well does the practitioner's theoretical and conceptual knowledge translate into his/her capacity for clinical application?

This study defined the concepts of transference and countertransference according to the psychoanalytic paradigm, and it considered them within the context of the object relations model (Fairbairn, 1954). The major research questions (See Chapter 3, pp. 99-101, Major Research Questions) were addressed through the questionnaire designed by the researcher, and where applicable, the model of object relations, as clinically applied by D.E. Scharff and J.S. Scharff (1987), and by J.S. Scharff (1991) was adopted by this researcher as the framework within which to score therapists' responses to various items on the survey, including open-ended questions. (For further details, see Appendix A, The Questionnaire: Respondents' Responses to Items as Reported through Frequencies, and Appendix B, Coding and Scoring.)

Chapter 2 follows and offers a comprehensive review of the literature in the field, which includes the theory of romantic love and that of mate selection from the psychoanalytic perspective, the meaning and significance of being a couple, and the implications for a couple in love, in crisis, and within the counselling context. A detailed history and overview of the psychoanalytic paradigm are also included, as well as a description of the object relations model (which is psychoanalytic), definitions of key concepts, and an examination of the meaning, significance, and use of the concepts of transference and countertransference within the therapeutic relationship and as they relate to this research study. Chapter 3 outlines the methodology of this study and includes a detailed description of the sample, the research instrument, the ethical review process, and the overall procedure involved for this study. Chapter 4 outlines the results of this study and details the tests employed to determine these results. Chapter 5 presents the discussion section, which includes a summary of the findings of this study in further detail, the conclusions and concluding comments from this researcher, as well as further implications of this study.

Since the theme of this doctoral dissertation is "the dance" that couples do with and to each other dyadically, and "the dance" that the practitioner who engages in couples counselling does triadically with the couple, the reader will find references to the dance metaphor that is distinct to the couple system and relevant to this research study throughout this dissertation.

Part 2:

Chapter 2

Review of the Literature: An Overview of Romance, Love, Mate Selection, and Coupledom/Marriage: The Commitment of Being a Couple from the Psychoanalytic Perspective - The Theory, the Practice, and Key Concepts

A Brief Introduction:

The following section on the psychoanalytic theory of romantic love (Section 2.1, Love and Psychoanalytic Theory) is being presented to set the tone for this research study. It is important for therapists, researchers, individuals, and partners who are involved in romantic relationships to understand the unconscious mechanisms that have drawn two mates toward "choosing" each other and that continue to motivate them in their dyadic relationship as a couple. It is also essential to comprehend the theory that explicates this process. The theory presented here provides a framework within which researchers and clinicians are better able to understand couples, and within which they can help couples to better understand themselves and each other as dyadic partners.

In the context of this research study, the reader has been provided with the appropriate theoretical framework to both emphasize and elucidate the dyadic dance done by couples and the dyadic dynamics of that dance. In the treatment of couples, the couples therapist will seek to reveal to partners their own unique dance steps, in order to help partners perceive with new insight and understanding how and why they are doing the dance steps that they do, and to assist partners in the change process toward healthier relating on both an intrapsychic and an interpsychic level. This "dance" theme is found throughout this study from its inception through to its conclusion.

It is necessary to first examine the various phases of coupledom experienced by the couple system in order to understand the experience of two partners as they navigate through the initial phase of romantic love, struggle as they grow through the process of encountering elements of a

more mature love in their attempt to merge as one couple, confront conflict, and then experience couples counselling within the psychoanalytic framework. It is within the psychoanalytic model that the tools of transference and countertransference will help the partners to heal together through a therapeutic process of intricate uncovering, discovering, and then recovering, as two individuals and as one couple.

Section 2.1: Love and Psychoanalytic Theory

> Psychoanalysis and love are intimately related. Why we love, who we love, and how we love, can best be explained and understood within this theoretical paradigm.
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> Love as a human experience is a topic particularly dear to psychoanalysis. The capacity to love is one of the main indicators of a well-functioning individual and obstacles to loving or maintaining a loving relationship are a major limitation to emotional life. Indeed, clinically, one of the frequent reasons patients seek analysis is because of such difficulties.
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> (Schneider, as cited in Ahumada, Olagary, Richards, & Richards, 1997, p. 407).

Schneider also noted, "psychoanalysis has a developmental theory of love involving the ability to fall in love, to experience mature love, and, most importantly, to maintain that feeling." (Ibid.).

Whether an individual has the capacity to love and care for another and whether that capability is limitless or limited, conditional or unconditional, functional or dysfunctional; whether he/she can experience that love in a mature and healthy manner as opposed to an immature or regressive manner; and whether the individual is capable of giving, receiving, and sustaining the experience of committed love in a reciprocal way, can be clinically discovered within the psychoanalytic paradigm. The roots of these healthy or unhealthy patterns can also be revealed through the use of **transference** and **countertransference**.

Transference and countertransference are ubiquitous natural phenomena that are central concepts within the psychoanalytic paradigm. Transference is always present in all interpersonal

relationships, including the initial one shared by infant and caregiver that forms the foundation for all future relationships that the individual later experiences in adulthood, most notably the one shared with his/her mate. Transference can take the form of feelings, thoughts, attitudes, and/or behaviours that belong to the individual, primarily on an unconscious level, originating in an earlier relationship with someone of significance in the past and being directed to someone of significance in the present. From the psychoanalytic perspective, the early infant-caregiver relationship and the interpersonal dynamics inherent in it have not only impacted upon the individual's unconscious selection of his/her romantic partner, but they are also impacting on the nature of the couple's shared intimate, romantic relationship in the present. Within the couple system itself, the individual partners direct transference *to* each other and experience transference *from* each other. In the context of the therapeutic relationship, transference can take the form of feelings, thoughts, attitudes, and/or behaviours that *belong to the individual client/patient* or, in couples therapy, to *both partners as individuals and to the client couple/patient couple*, mainly on an unconscious level. Within the therapeutic relationship, the individual client or the client couple in therapy unconsciously directs these transferential feelings, thoughts, attitudes, and/or behaviours toward the therapist.

Transference is generally defined as, "The displacement of patterns of feelings, thoughts, and behaviour, originally experienced in relation to significant figures during childhood, onto a person involved in a current interpersonal relationship." (Moore & Fine, 1990, p. 196). This process is mainly an unconscious one, and therefore, "...the patient does not perceive the various sources of transference attitudes, fantasies, and feelings (such as love, hate, and anger)." (Ibid). **Countertransference** is generally defined as, "...an analyst's feelings and attitudes toward a patient" (Ibid, p. 47), which may be, "...derived from earlier situations in the analyst's life that have been displaced onto the patient." (Ibid.) It is important to note, by way of differentiation, that countertransference is always present in the *therapeutic* relationship, and *belongs to the therapist/analyst*. "Countertransference therefore reflects the analyst's own unconscious reaction

to the patient, though some aspects may be conscious." (Ibid.). Transference and countertransference have somewhat different meanings depending on specific psychoanalytic paradigms. These concepts will be discussed in further detail in Section 2.7, Transference and Countertransference.

Person (1988) postulates that falling in love is directly connected to the need to be the most significant person in another's life. The foundation of the psychoanalytic paradigm is predicated on the belief that the romantic/marital partner is the person who is closest to the individual and with whom he/she shares the most intimate relationship. Person maintains that, "We long for intimacy, for priority, for the exaltation of love." (Person, as cited in Schneider, 1997, p. 412). The romantic partner to whom the individual is first "attracted" and the dyadic relationship that the two partners form are actually "mirrors" of the initial caregiver and the caregiving relationship from childhood respectively, whether functional or dysfunctional. It is with this partner and within the intimate, romantic relationship that the old patterns are reenacted, the old conflicts resurface, and the past feelings arise...to be "played out" again and again, with the unconscious desire for a new and happier ending that never occurs. The "dyadic dance" continues to the same tune and with the same steps, despite a new partner who is unconsciously viewed and responded to as an "old ghost" from the past. (Lankton & Lankton, 1992; Kershaw, 1992; Lachkar, 1992; Sharpe, 1997; Solomon & Siegel, 1997). This is the "unconscious repetition" that Freud (1910) observed in children's play and in the actions of individuals in adulthood. It resurfaces within the intimate, romantic relationship shared by partners, and it can be observed in their conscious and unconscious dance in the present, as well as traced back to their unconscious dance from childhood and from their past as individuals.

The "**couple**" can be defined as the union of two individuals who share a mutually loving, caring, and committed intimate relationship. This definition can also be perceived as *the ideal* that all romantic partners hope for and plan on, and in the therapeutic setting, the objective that the couples therapist and the partners strive to attain together within the therapeutic triad.

While Freud's (1910, 1914) focus was on the self of the individual and its intrapsychic functioning in terms of the development of the id, ego, and superego, Kohut's (1971) focus was on the study of the self and the self-in-relation-to-other, and the interpsychic dynamics at play within these significant relationships. However, Kohut only emphasized the other as an aspect of the self. Fairbairn's (1952, 1963) focus was on the 'object-seeking' self and the significance of internalized (object) relationships that impact upon the later relationship shared by partners. As Freud postulated, the healthy or unhealthy development of the ego or the self, formed during infancy and childhood within the early infant-caregiver relationship, would determine the individual's needs, desires, and self-functioning in adulthood, as well as the individual's perception of others. According to Freud, these unconscious repetitions by the individual in adulthood are continual strivings for a desired resolution that is never attained.

Based on Freud's theory, individuals are unconsciously motivated to choose romantic partners who "remind" them of early caregivers and "familiar" feelings of these past experiences. It is no surprise then, that although individuals would reenact the same dramas again with new partners, nevertheless these dramas would have the same ending.

There is an inherent desire of the self to be "whole" or "complete" and "cohesive" (Kohut, 1971, 1977), which naturally motivates the self to merge with the self of the other, as a means to become "fused" or "whole". In fact, Solomon (1989) states that, "A fused attachment begins at the time the partners first 'fall in love'. In the passion of a new love, the idealization process begins and both experience themselves as whole and loved." (pp. 40 - 41).

Consciously, the self of the individual is seeking certain overt qualities based on its needs, desires, and wishes, which may or may not be verbally expressed. As well, unconsciously, the self is seeking that which is familiar from childhood in order to go back and "fix" something that was "missing" or "wrong", or to "mirror" something that was perceived as "good", or that may even be harmful but nevertheless feels psychologically comfortable to the individual in some way(s) and therefore unconsciously draws him/her to repeat it in his/her romantic relationship

with his/her partner in the present. The "spark" or "chemistry" that individuals frequently experience and the "feeling of familiarity" that they sense, even upon a first meeting, are actually the results of the unconscious mechanism of transference. This unconscious mechanism is pulling the potential mates together to heal old wounds and thus enable partners to be naturally and psychologically cured together in their interaction as a dyad. Unconsciously, there are elements about each potential partner that trigger a familiar response in the other, whether positive or negative; as well, a feeling within the relationship that seems to be "comfortable". In reality, the partners are unconsciously feeling "at home" with each other in the present because they are, in fact, unconsciously back "at home" in their past, re-experiencing within the earlier caregiving relationship with the caregiver.

Romantic love may be defined as the passionate feeling that two individuals experience in their shared sense of attraction, desire, and being in each other's physical presence or thoughts. **Love** may be defined as a heightened and healthier function of attraction and desire, and a deeper level of intimacy and commitment that is ideally shared by two partners. **Romantic** love tends to be the feeling that is experienced by two individuals at the initial stage of their meeting and during the courtship stage; later, as the relationship and the partners grow through change, a stronger, more mature, heightened, and more **realistic love** takes hold.

The statement that, "...**love** arises from within ourselves, as an imaginative act" (Schneider, as cited in Ahumada et al., 1997, p. 412) refers to the unconscious seeking that the self engages in while being attracted to a potential romantic mate. The self subconsciously creates the ideal partner, or "imago" (Hendrix, 1988), and then projects these expectations and attributes onto the other partner, re-creating that partner as he/she imagines him/her to be, and not in the way that he/she is exists in reality. When these unrealistic expectations are not fulfilled and the self-needs not met, conflict arises between the two mates.

From the psychoanalytic perspective, "it [love] fulfills our deepest longings and our oldest dreams." (Ibid.). Both partners look to the other to meet their innermost desires, needs, and

wishes within the intimacy of the dyad, as well as the residual needs and desires from their past, specifically from their childhood. This is the purpose of love from a psychoanalytic perspective: to help the self heal itself through the fusion with another, within intimacy, within the interactional system, and through the interplay of the dynamics of the psyches of both selves. It is in this way that transference is useful as a tool, not only in the unconscious process of mate selection, but also in the process of reenactment for both partners as a couple in the natural curative technique. "Perhaps we could say that marriage is an amateur attempt at psychotherapy." (Whitaker & Keith, as cited in Stahmann & Hiebert, 1987, p. 21).

While Person (1988) expresses the two main questions regarding love that is posed by many, specifically why individuals fall in love when they do and why they do (i.e. how and why they choose their romantic partners), it is the psychoanalytic paradigm that offers an explanatory framework with which to study these questions, and the tools of transference and countertransference with which to further examine these questions and provide significant answers.

"Typically, psychoanalysts think of love as arising out of early developmental experiences" (Ibid.), and it is interesting to note that, "The basic philosophy behind Imago Therapy (developed by Harville Hendrix) is that relationships are Nature's way of bringing two people together who have been wounded at the same place developmentally, so they can heal the wounds of their childhood." (Brothers, 1996, p. 14). Stahmann and Hiebert (1987) state that, "Mate selection is one of the most accurate choosing processes that human beings engage in" (p. 18), and they maintain that, "...human beings choose exactly the mate they need at that point in time." (Ibid.).

In general, psychoanalytic theorists place great significance on the self and its continual desire to merge with another self to be "whole". (Freud, 1910; Kohut, 1971). In the initial stage of romantic love, partners physically and emotionally, consciously and unconsciously, desire a sense of intimacy and a sense of merging or oneness with each other; these are natural and inherent elements of the self. Freud (1900) referred to the "psychic reality" to express an individual's

innermost unconscious motivations, including the desire for the self to be whole and for the ego to be functioning well. It is significant to consider Person's (1988) theory of romantic love as it relates to the concept of being a couple, the transformation that occurs from the two distinct "me" psyches of the two separate individuals into the combined "we" psyche of the dyad, and the "merger" that occurs in many ways to transform the couple, formerly two selves, as they seek to become one being. Inherent in this natural transformation are the magic and the mystery found in the romantic relationship, as well as the conflict that eventually ensues. Stahmann and Hiebert (1987) state that, "The desire to grow, the desire to be completed in some way, is a powerful force at work in individuals" (p. 21), and they maintain that, "this force brings people together, binding them in a relationship." (Ibid.). There is a dialectical relationship between the need and desire for closeness on one hand and the universal striving for self-definition on the other; this phenomenon accounts for the conflictual feelings that push partners apart.

It is essential to emphasize that, "Many people have a hard time accepting the idea that they have searched for partners who resembled their caretakers." (p. 35). While there are conscious forces present in mate selection, there are strong, unconscious mechanisms at work as well, of which most people are not aware. Hendrix (1988) postulates that, although both the positive and the negative traits of caregivers are significant, the negative traits are stronger and more influential, and individuals are unconsciously attracted toward individuals with whom they can repeat these old dramas from the past, hopefully resolve old issues, and have a healthier functioning relationship. Hendrix states that, "To guide you in your search for the ideal mate, someone who both resembled your caretakers and compensated for the repressed parts of yourself, you relied on an unconscious image of the opposite sex that you had been forming since birth" (p. 38) that Hendrix refers to as the "imago", and De Angelis (1992) emphasizes that, "Your unconscious mind will seek to complete its emotional unfinished business from childhood by getting you to 'choose' people who will help you re-create your childhood dramas." (p. 70). According to the psychoanalytic perspective, in the initial stage of romantic love or the attraction

phase, this psychological and emotional unconscious process of "choosing", which is actually more of a "guiding" phenomenon, is called **transference**.

> The psychological term for this case of mistaken identity is "**transference**", taking the attributes of one person and overlaying them on another. It is especially easy for people to transfer their feelings about their parents onto their partners, because, through a process of unconscious selection, they have chosen partners who resemble their caretakers.
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> (Hendrix, 1988, p. 59).

Ahumada et al. (1997) also discuss the importance of the imago. These authors maintain that individuals connect on both a conscious and an unconscious level as they seek their imago, the idealized partner. In mate selection, the potential mates are attracted to each other and non-verbally communicate with each other on an unconscious level. Just as transference is instrumental as an unconscious motivation toward the "choice" of a romantic partner in romantic relationships, transference and countertransference are efficacious tools within the psychoanalytic therapeutic setting as well, which may be used to help partners heal individually and dyadically.

The psychoanalytic theoretical framework provides a clear explanation for romantic love, in terms of the ongoing need of the self to bond with another. The desire of the self to "merge" and become "whole", as postulated by Freud (1910, 1914), Sullivan (1953) and Kohut (1977), is echoed by Person (1988) who also refers to, "the sense of merger and transcendence" (p. 63), and states that, "Lovers may go beyond a sense of joint identity, may feel that they have in fact merged." (Ibid.). Perhaps when couples seek counselling, they do so because, in many ways, they no longer feel "merged", but rather "fragmented" within their dyadic unit.

The initial phase of idealization and the normative phase of realization that gradually follows, result in conflict within romantic/love relationships. This natural phenomenon concerning romantic/love relationships is explained well by psychoanalytic theory, and accurately described by Solomon and Person, respectively. According to Solomon (1989), "The state of love enhances the self through the process of fusion and idealization. For a time two become one; it feels

timeless and forever." (p. 40). Person (1988) states that, "Love is one of the great transcendent experiences" (p. 86), and maintains that, "While it [passionate love] has its roots in our biological nature, it also expresses our highest aspirations, our longing for transcendence through merger." (p. 87). Consciously, individuals have aspirations of being with a specific type of romantic partner and being involved in a certain type of romantic or intimate relationship. Unconsciously, individuals have additional desires and needs that motivate them toward very specific potential mates and very specific romantic relationships. This theory of love, placed within the psychoanalytic paradigm and thus framed well for our understanding, clearly demonstrates why and how individuals "choose" the partners whom they do, and explains the romantic relationship that unfolds; how and why the old dramas are replayed with the same unsatisfactory ending, the needs and desires remain unmet or not met in the way longed for, and consequently, the resulting pain, sadness, disappointment, disillusionment, and conflict follow.

In concluding this section on the psychoanalytic theory of romantic love, and prior to exploring the meaning and significance of being a couple once the two individuals have become partners within a dyadic relationship, it is important to briefly summarize the transition that two partners experience as a couple, from the initial phase of romantic love through to the more realistic stage of love. It is in this stage that, "After the idealized fusion of romantic love, partners begin the unconscious work of determining what they can expect in the way of emotional fulfilment." (Solomon, 1989, p. 41).

As previously discussed within this section, two partners unconsciously "choose" each other and then enter into coupledom idealistically. Upon merging into one dyad, they enjoy the ensuing feelings of elation, completion, and a sense of fulfilment during the initial phase of their relationship. As the couple enters the intermediate stage of their relationship, the unconscious motivations seek the fulfilment of their innermost needs, desires, and feelings that have long been deeply embedded within their psyches. This sudden transition away from the "other-focused" psyche that was previously "we" oriented and the return to the former "self-focused" psyche that

is again "me" oriented, is a disappointing but realistic shift that occurs in all love relationships. Most individuals are consciously unaware of this reality until it literally "hits home" in their own relationship. In couples counselling, the therapist facilitates the couple as individuals and as a dyad, to develop an awareness of and then to acknowledge their passage from idealization to realistic realization, and then helps the couple to understand this process as a normative one that they can "go through", "grow through", and ultimately "survive" together through greater insight, enhanced understanding, and a healthier way of relating as loving partners within their intimate relationship.

The next section continues the discussion of the significance and implications of being a couple from the psychoanalytic perspective, once the two individuals have merged into one dyad. The "couple myth" that reinforces both mates' concepts of the *idealized* partner and the *idealized* couple will be further explained since it is a potent mechanism for couples, as well as the conflictual responses that partners experience in their interpersonal relationship as they seek to mediate their hopes, needs, and desires with their current reality. Finally, the therapeutic treatment of the couple in counselling will be discussed, focusing on the concepts of transference and countertransference, and offering a preliminary introduction that illustrates how these concepts may be clinically considered and applied as therapeutic tools to understand and intervene with couples. A more detailed discussion of transference and countertransference will be included in Section 2.7, and their application to couples counselling will be described in detail in Section 2.8.

Section 2.2: On Coupledom/On Marriage/On Being a Couple: The Significance and Implications

Research studies demonstrate that individuals exist in a couple relationship 85% of their life, but 80% of partners are unhappy in their romantic relationships. (Money, in Frolick, 1999). Additionally, according to recent statistics (Statistics Canada, 1999 and 2000), the rate of marriage is decreasing while the rate of divorce is increasing, or in other words, successful

relationships are on the decline while the rate of failure for relationships is escalating. (Gottman with Silver, 1994). Yet, "With divorce so commonplace in Western society...it seems curious - and touching - that...by and large, a monogamous marriage is still held out as an irreproachable ideal." (Danziger, 1992, p. i).

It is certain that "a couple myth" exists, which is a key concept that will be discussed and explored later within this section. Everyone has an ideal image of his/her partner prior to even meeting him/her, and an ideal of the type of romantic relationship for which he/she hopes, a preconceived notion of what life will be like as a couple. Once the potential partner and the opportunity for this romantic relationship to develop present themselves, the individual consciously and unconsciously attempts to "fit" his/her partner into the idealized role and the idealized relationship that have already long been created. "Freud first described the process [idealization] in connection with the phenomenon of falling in love" (Moore & Fine, 1990, p. 91), since it is during this phenomenon that, "The self as well as the object may be idealized." (Ibid). The "internal couple" (Winnicott, 1967; Scharff, D. E. & Scharff, J. S., 1991) refers to the internalization of *the ideal couple* and *the couple myth* that each partner has created for him/herself on an unconscious level and attempts to re-create on both a conscious and an unconscious level within his/her romantic relationship. In couples counselling, within the psychoanalytic paradigm, one of the objectives is to discover each partner's "internal couple" or inner/internalized couple and its origins, as well as its attempted maintenance within the couple system through various dyadic dynamics enacted through the couple's intrapsychic and interpsychic "dance".

Each individual has consciously and unconsciously created the desired scene, and he/she has been waiting for the potential partner to step in, take on the role, and enact the performance that is expected of him/her, perfectly. Both partners unconsciously perpetuate the shared couple myth that has been created by the couple, whether functional or dysfunctional. It is within this couple myth that each partner is attempting to fulfill his/her own needs, desires, and expectations, and to

play out the illusion of the relationship that he/she has long desired. However, gradually, for many couples, as time goes on, something does not "fit", and something is "not working".

> The myth of these couples gives rise to any shared collective fantasies, causing the couple to play and replay their roles with powerful passions. The scenario is like a play, a drama that is repeated again and again, back and forth, through the idealization and devaluation process, with the actors always yearning for a new ending.
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> (Lachkar, 1992, p. 59).

It is when these expectations are not met and the needs are not fulfilled, that conflict occurs and suddenly the partners are confronted with a reality that clashes with the idealization, the fantasy, and the myth. The partners need and desire a happier ending to their ongoing performance, which is actually a new beginning for them as a couple, as opposed to their continual replaying of their past.

The detailed longing of the self to "merge" with another as the explanation for falling in love, from the psychoanalytic perspective, was the subject of the previous section (Section 2.1). As the couple moves from the initial, idealistic stage of their romantic relationship into a more realistic one, there are new issues that surface and frequently resurface, and that need to be resolved; these are considerations for both the couple in counselling and the couples therapist. In couples therapy, the therapist needs to explore the couple's relationship in the past as well as their relationship at present, to help them understand the shift and the reason for what is considered to be a normative transition. (Sternberg, 1986).

Although the merger or the attempted merger of two selves into one whole entity, conjures up a beautiful and much sought-after image, nevertheless it is this clash of two separate selves with two very distinct identities, striving and struggling to become one, that brings forth the resultant conflict.

As postulated by Freud in the early 1900s, when he observed the "repetitious acts" performed again and again by children at play and these similar repetitious patterns later played out by

individuals in adulthood, the self of the individual is continually striving to attain a sense of completion and seeks this through connection with the self of the 'other'; however, this objective is a continual unattainable pursuit of the psyche. Herein lies the dilemma and the resultant conflict for the partners in a relationship, who are continually endeavouring on a conscious and an unconscious level, to seek a sense of completion that never comes.

The two individuals struggle on a conscious level and the two selves struggle on an unconscious level to achieve unity as a couple. The conscious and unconscious feelings and behaviours reflect this desire to be a wholly fused entity. Nevertheless, the reality remains that the two partners are still two separate individuals with two distinct personalities, different past histories, and previous experiences that gradually reinforce feelings of loneliness, sadness, and a lack of fulfilment. As the disillusionment and disappointment surface, the clashes and conflict begin. The dyadic dance begins, is maintained, and reinforced by both partners.

Lang (1985) asserts that, "There is a driving passion in new love which overcomes reason, logic, and the wish to be a separate autonomous person." (p. 40). However, as Person (1988) emphasizes, "To the extent that the lover's goal is merger, he must fall short of it; and the closer he comes to achieving it, the more he will feel his autonomy threatened." (p. 87). As previously stated, herein lies the conflict within romantic relationships of which individuals and couples are unaware, and yet, the difficulties and feelings that they bring with them to couples counselling are manifestations of this unconscious conflict. Modern-day writers and popular psychology authors often describe this unconscious conflict as a physical and psychological "moving closer and pulling away" movement that partners experience during this intermediate stage of their relationship, where they have a strong desire for intimacy and yet the fear of it, the desire to merge as one and yet to also retain a sense of individuality and autonomy. The partners are experiencing the beauty and the frailty of love, as well as the power and the fear of love, and they do not have an awareness or an understanding of their feelings and the dilemma.

Person (1988) maintains that, "Mutual passionate love is the most complete form of romantic love" (p. 51), and that,

> In affectionate bonding, the form of love generally most highly touted by mental health professionals, a couple gradually develops deep and reliable ties of mutual caring, interests and loyalty. They come to believe in one another and to feel assured of the on-going sustaining nature of their relationship. (Ibid., p. 51).

These statements are significant to social work clinicians, researchers, educators, and to couples themselves within their dyadic union because of couples' ongoing desire to have a happy, successful, and fulfilling relationship, and the desire of clinicians, researchers, and educators who aim to facilitate this process and accomplish this objective in the area of couples counselling.

It is important to understand the elements and the dynamics of romantic love and the couple unit, the dynamics of the psyche of each partner, and the dynamics of the psyches of both partners in interaction as a couple, as well as the dyadic dance in which each couple engages. When partners do end one relationship and later begin a new journey with another partner, the dance still remains the same. The same patterns emerge, the same dance steps are done to the same tune...only the partner and the relationship are different, or so they seemed initially. When the disappointments resurface and the old conflicts are replayed yet again, partners need insight as well as improved understanding of why this happens and what needs to be done in order to effect positive change and to have the happier, more fulfilling relationship that they desire.

According to the premise of psychoanalytic theory, the conflict arises as a reenactment of old issues from each individual's past, from within the earlier caregiver-infant/child relationship where needs were not met or satisfied appropriately. As stated earlier, certain desired behaviours and emotional responses from childhood take the form of anticipation and expectations in adulthood that are projected upon the mate, in order to "mirror" that which was previously experienced and is still desired, and/or to "fix" that which was missing. The present partner and the dyadic romantic relationship act as unconscious reflections of the primary caregiver and the

initial caregiving relationship from the past, whether functional or dysfunctional. Frequently, this is a revelation to partners who are hearing and acknowledging this reality for the very first time, in couples therapy.

As discussed in further detail in Sections 2.4 and 2.5 where an overview and a brief history of the psychoanalytic paradigm and the object relations model (which is psychoanalytic) will be presented respectively, it is within the psychoanalytic paradigm and with the efficacious tools of transference and countertransference that the sources of the partners' difficulties can be traced back to their past through a reenactment in the present. Partners may then be facilitated to learn and integrate new and healthier patterns of relating as a couple in the present and for the future.

While couples as individuals may be aware of their own **conscious** needs and desires, as well as their expectations and hopes of a romantic partner and of an intimate relationship, partners are not always aware of their own **unconscious** needs, wants, and desires, and the unconscious mechanisms that propel them as individuals to not only choose the romantic partners whom they do, but also the type of romantic relationship in which they find themselves, and the type of "dyadic dance" that they do to, and with each other. The steps are the same, and so is the end result. What are these unconscious forces, where do they come from, why do some romantic relationships work and work well, while others do not work well or work out at all? When couples and couples counsellors understand the forces at play, both consciously and unconsciously, they are better able to understand themselves and each other, and they are facilitated to work together as true partners in the mutual process of making both the therapeutic relationship and the dyadic relationship for couples, relationships that "succeed".

Within the psychoanalytic paradigm, the therapeutic tools of transference and countertransference may be effectively used to help the couples therapist to observe the dyadic "dance" in which the partners are engaged, the roles that they are playing, and the steps that they are taking toward or away from each other in their relationship. The tools of transference and countertransference are the tools that the couples therapist brings with him/her as he/she joins the

dance, to uncover the symptoms of frustration, confusion, misunderstanding, and pain, to discover the roots of these old wounds and long-embedded needs, and to facilitate the couple in newer, healthier ways of fulfilling their own needs and desire, hopes, and dreams, in addition to those of the other/partner that are equally significant and equally valid.

The purpose of the previous two sections outlining the theory of romantic love and the state of coupledom from the psychoanalytic perspective is to provide a framework for this research study. This researcher has presented a framework for this study in the same manner in which two individuals as partners and the couples counsellors who treat them, need to approach coupledom. Both couple and couples counsellor need to have a firm foundation in the form of a strong knowledge base about the unconscious forces within each individual's own psyche and those of their partner, which have not only propelled them to initially "choose" each other, but which also determine how they "choose" to dance or dyadically interact with each other in their relationship as a couple in the present. If two partners lack this insight into themselves and each other, as well as into their relationship as a dyad in interaction, then this role and responsibility will rest with the couples counsellor working with the couple, within the psychoanalytic paradigm. This objective will be one of the essential goals of treatment for the couple in couples therapy.

This researcher would like to conclude this section by briefly defining the essential concepts of marriage and/or being a couple, in order for the reader to have a shared, clear understanding of these key concepts, just as the couple needs to ideally have a shared understanding of themselves, each other, their relationship, and their present pattern of relating and communicating, in order for them to develop and maintain functional and effective patterns of relating and communicating within their relationship, both in the present and in the future.

For purposes of this research study, this researcher offers the reader, the following operational definitions: Marriage can be defined as a union or an institution comprised of two partners within and according to the requirements of civil and/or religious law. Being a couple or coupledom, which is a relatively common term that has surfaced in the literature on couples, has a definition

that is similar to that of marriage. Being a couple within a romantic relationship also implies a sense of intimacy and a form of commitment shared by two partners, in a mutually loving and caring union, with a shared understanding of their relationship, its responsibilities, obligations, and parameters.

Often, as will be further discussed in Section 2.3, couples who come to therapy, whether married or not, do not have the "shared" understanding previously mentioned or a healthy way of communicating this frustration and disappointment as partners. Frequently, partners do not understand how they "started from the same place" together at the initial stage of the relationship, only to find that they are "far apart" in ways that they did not imagine, and that their partner is acting, feeling, and being the very opposite of what was anticipated. Once couples can fully understand how the self and the inner psyche function, they can better understand how and why they act out and reenact the same patterns, or why they "do the same dyadic dance" in the same ways, whether or not the dance is done with the same dancing partner, a different one, or a series of different partners. Without awareness, insight, and intervention, individuals hear the same music, they dance as a couple to the same tune, and they do the same steps...over and over again. Changing partners does not always assure the desired responses and the ultimate relationship sought, although at times it does. It is the honest and open exploration of self and self-in-relation-to-other that will lead partners as individuals and couples to the origins of their intrapsychic and interpsychic needs and desires, facilitate their own interpretation and understanding of the previously hidden roots of their intrapsychic and interpsychic functioning, and help couples as partners to channel their needs in healthier communication and other relational patterns with the mate. This exploration of self and self-in-relation-to-other can occur within the safety and security of the psychoanalytic therapeutic setting where the therapist and the dyad become triadic partners in the therapeutic process.

It is only when couples and couples counsellors become consciously aware of these unconscious patterns and the active part that individual partners and couples play in repeating

them, that they can break these maladaptive patterns, end the dysfunctional cycle, and create new and healthier ways of functioning, both within themselves and within their relationship with the partner, in order to mutually maintain a happier and healthier relationship as a couple. As Ornish (1998) states emphatically, based on his own theories of love, intimacy, and the results of his research studies focusing on the positive impact that a fulfilling intimate relationship exerts on individuals' physical and emotional health, "Awareness is the first step in healing." (p. 24).

Again, for the purposes of this research study, this researcher would like to clarify that not all couples are married or living together within a common law union, but these dyadic units can still be defined as a "couple" by the unique structure, characteristics, and dynamics that exist in their dyadic relationship. As Molnos (1998) affirms, "What used to be called marital therapy and marital counselling is now couple therapy and couple counselling." (p. 1). According to Molnos, "These terms reflect more accurately the current social reality as couples seeking help are often unmarried and some are homosexual." (Ibid.).

In this research study, the following terms are being used interchangeably: "marriage", "being a couple" and "coupledom"; "dyad", "couple", "dyadic unit" and "couple system"; "marital therapy", "couple therapy" and "couples counselling", since many of the couples who come for counselling are not married, and many of the characteristics and dynamics of couple systems are the same, whether these dyads exist within the marital context or outside of it. Married or unmarried, same or opposite gender, having similar or dissimilar issues of concern or conflict, the basic characteristics of a couple and the underlying dynamics are common to most couples. It is the distinct "dyadic dance" that is unique to each couple.

Prior to examining how the psychoanalytic paradigm and the tools of transference and countertransference can assist couples counsellors in helping couples to uncover the sources of their difficulties, it is relevant to take a brief look at the state of being a couple today, recent trends, and the staggering statistics. Section 2.3 offers an overview of the implications for couples today, in the face of an increasing rate of breakdown and breakup for couple systems, and

what Gottman and Silver (1994) refer to as, "...a frightening time for...couples" (p. 16). Current trends and statistics regarding the state of coupledom will conclude the section, and highlight the need for understanding and treating couples at a time when it is evident that couples are in conflict, in crisis, and seeking counselling.

Section 2.3: Being a Couple Today: Current Trends and Staggering Statistics

Danziger (1992) states that, "Even in the last few years of the twentieth century, we are still every bit as romantic and hopeful as our ancestors who worshipped the ideal of courtly or chivalric love half a millennium ago". (Ibid.). Weeks and Hof (1994) concur: "High divorce rates notwithstanding, marriage in America is more popular than ever." (p. 19). To further clarify this statement, it is important to note that while both American and Canadian statistics demonstrate that fewer people are marrying, nevertheless a large enough percentage of individuals are marrying and/or becoming involved in couple relationships. In fact, according to American statistics, "More than 94 percent of the American people marry at some time in their lives" (United Nations, 1983, as cited in Barker, 1984, p. 19), and it is encouraging to note that, "Even those who have gone through the wrenching experience of divorce retain their fundamental approbation for marriage." (Ibid.).

Current statistics regarding marriage and divorce in both the United States and Canada present concerning trends. From 1999 through 2003, the number of marriages in Canada has increased; however, this is also the case for the number of divorces. According to Statistics Canada (2004, April 8a), there were 14,877,041 married persons of both genders in 1999, and 15,416,565 married persons of both genders in 2003. Statistics Canada includes in their classification of married persons, "...persons legally married, legally married and separated, and persons living in common law unions." (Ibid.). Recent statistics demonstrate that, "The number of couples who got married in Canada hit the highest level in five years in 2000." (Statistics Canada, 2003, June 2). It is noteworthy that,

> In 2000, 65.3% of marriages were first marriages for both the bride and groom. This proportion was down from 73.5% in 1980. Marriages in which one or both partners had been previously divorced accounted for 32.6% of marriages in 2000. Two decades ago, only 23.6% of marriages involved a previously divorced bride or groom. (Ibid.)

These statistics display a growing trend. As indicated by the increase in the number of marriages where one or both mates has been previously married and divorced, and the rising number of divorces that have taken place over recent years, there is a realistic crisis for couples who are seeking fulfilment within their marital unions and yet not attaining it.

Just as the number of marriages has gradually increased in Canada from 1997 through 2000, the number of divorces has steadily risen from 1997 through 2000 as well. In 1997, the number of divorces was 67,408; in 2000, there were 71,144 divorces. (Statistics Canada, 2004, April 8b). In Ontario, the number of divorces has also steadily increased from 1997 through 2000. There were 23,629 divorces in 1997 compared with 26,148 divorces in 2000. According to statistics regarding population trends by marital status and gender, there was an increase in the number of both male and female persons who were divorced, from 1999 through 2003. There were a total of 1,477,108 divorced persons in Canada in 2003. (Ibid.).

Statistics Canada states that, "Following amendments to the *Divorce Act* in 1985, the number of divorces increased more than 20% in 1986 and 1987. In 1987, an all-time high of 96,200 couples had their divorce finalized." (2002, December 2). As well, "That year, the crude divorce rate also reached a record high, 362.3 divorces per 100,000 couples." (Ibid.).

According to Statistics Canada, "The number of marriages ending in divorce rose for the first time in four years in 1998." (2000, September 28). This report states that, "A total of 69,088 couples divorced in 1998, up 2.5% from 1997. As a result, the crude divorce rate rose slightly from 225 divorces per 100,000 Canadians in 1997 to 228." (Ibid.) According to this report, "Based on 1998 divorce rates, 36% of marriages are expected to end in divorce within 30 years of marriage." (Ibid.). Another trend can be noted, concerning individuals who marry and divorce.

Although recent research studies demonstrate that individuals are marrying later in life, research also demonstrates that, "In recent years, both men and women have been getting divorced at a later age. In 1998, the average age at divorce was 42.0 years for men and 39.4 for women." (Ibid.).

In 1998, in Ontario, "The rise in the number of divorces was seen in most provinces and territories..." (Statistics Canada, 2000, September 28). During this time, "In Ontario, 25,149 couples got divorced, 1,520 (6.4%) more than in the previous year." (Ibid.). It is noteworthy that, "The slight increase in the crude divorce rate in 1998 contrasts with the trend of generally declining rates since 1987." (Ibid). Statistics Canada reported that, "More marriages ended in divorce in 2000, the third consecutive year of growth in the number of divorces." (2002, December 2). These statistics reveal that, "A total of 71,144 couples had a divorce finalized in 2000, up a marginal 0.3% from 1999, and up 3.0% from 1998." (Ibid.). According to this report, "The risk of divorce varies substantially with the duration of marriage. The lowest risk of divorce in 2000 was in the first year of marriage, with less than one divorce for every 1,000 marriages." (Ibid). This report also notes that,

> The risk of divorce increased dramatically with each additional year of marriage. After the first anniversary, the divorce rate was 5.1 per 1,000 marriages. This increased to 17.0 divorces after the second anniversary, 23.6 divorces after the third, up to the peak of 25.5 after the fourth anniversary.

It is noteworthy that, "The risk of divorce decreased slowly for each additional year of marriage after the fourth" (Ibid), and that, "The majority (60%) of divorces in 1999 and 2000 were of couples married for less than 15 years." (Ibid.). These findings suggest that the challenges of marriage as well as the ability to mediate these challenges while maintaining a happy and fulfilling relationship, appear to be more difficult during the early years of a marital union. Recent statistics demonstrate that even for couples who have been married for 30 years, although their risk of divorce decreases slowly, nevertheless there has still been an increase in the number

of these couples who divorced from 1999 to 2000. As reported by Statistics Canada, "The proportion of marriages expected to end in divorce by the 30th wedding anniversary increased slightly, to 37.3% in 1999 and to 37.7% in 2000..." (Ibid.).

A study of the overall population highlights that, "almost everyone who can marry does, at least once." (Carter & Glick, 1976, as cited in Barker, 1984, p. 19). It is also encouraging to know that, "Four out of five divorced people remarry, and half of them do so within a year of their divorces." (National Council for Health Statistics, 1982, as cited in Barker), which seems to reflect that hope still reigns over past discouragement. Barker emphasizes that, "Divorced people are as likely to remarry as people who have remained single, a clear example of how hope still prevails over previous disappointment." (p. 19).

As previously stated, recent statistics for 1999 and 2000 demonstrate that the rate of marriage is decreasing while the rate of divorce is increasing (Statistics Canada, 2000, December 2), which reflects current societal trends. Clearly, it is evident that there is a steady decline in successful relationships while the rate of failure for relationships is accelerating. (Gottman with Silver, 1994).

According to Statistics Canada's census results and the recent research study by Turcotte & Belanger (1997), "common law unions are proliferating rapidly in Canada" (p. 2). Research in this area demonstrates that, "since the early 1980s, the number of persons living common law has tripled." (Ibid.). An interpretation of these facts could be two-fold: Whether within a marital merger, a common law union, or another form of intimate relationship shared by two partners, individuals are choosing to be with a partner within an intimate relationship. This is still the primary choice of most people who desire love, affection, security, and the intimacy that the ideal romantic relationship and the desired, idealized mate are expected to provide. However, the rate of marriage has decreased and the preference for common law unions over marital ones has increased in Canada. (Turcotte & Belanger). These trends are facts that reflect a social and sociological reality, as well as a psychological reality in the form of a hidden fear, an uncertainty,

and a strong hesitation on the part of individuals regarding their attitudes toward the formation of and their involvement in a romantic, dyadic union.

Marriage is still viewed as the ultimate commitment, and one that individuals would like to feel more certainty about, prior to making it. Even common law unions do not reflect a high rate of success, mirroring the same sad phenomenon that marriages are experiencing...breakdown and breakup. Turcotte and Belanger's study also reveals that, "first common law unions are generally short-lived; they seldom lead to a long-term commitment outside the bonds of marriage." (Ibid., p. 14).

As Gottman (1994) has found, the divorce rate for both first and second marriages is escalating. (in Gottman with Silver, 1994). However, Jackson (1974) states that, "the record for second marriages is good - indicating that people can and do learn in their married behavior." (p. 120). This statement can apply to third marriages as well, in terms of these relationships being even more fulfilling.

Barker (1984) also presents the American statistics for remarriage, which are comparable to Canadian statistics in this area: "Of those who divorce, the average length of their first marriage is seven years. Of those who divorced again, the second marriage endures an average of five years." (U.S. Bureau of the Census, 1979, as cited in Barker, p. 19). Statistics Canada (1992, 1997) also offers data that reveals that remarriage is no more successful than a former, first marriage. Dumas & Peron (1992) state in their Canadian research study, that, "Some types of marriage are known to be more unstable than others, notably early marriages and remarriages." (p. 56). In contrast, various other (Canadian and American) research studies demonstrate that second marriages are more successful, in terms of lasting longer and being more fulfilling than first marriages, and that third marriages are even happier and more satisfying than second marital unions. There are strong arguments for both sides; however the statistics seem to display that some individuals do learn from their previous experience as part of a couple while others do not, and this is the significant differential factor.

It is difficult to learn from past experience when there is an awareness lacking, and an uncertainty about exactly what is to be learned. As will be discussed later within this research study, couples often develop an awareness and a sense of what is to be learned, as well as the skills of learning in a healthier way, for the very first time when they are in couples counselling.

The premise of romantic love from the psychoanalytic perspective is that individuals do function within an unconscious, repetitive pattern, repeating the same behaviours and communication styles, whether they are functionally or dysfunctionally "mirroring" or "fixing" that which they earlier experienced or missed in their initial childhood relationships with caregivers and/or later experienced in their previous relationships with former romantic partners.

As previously stated, "more than half of all first marriages end in divorce" (Gottman with Silver, 1994, p. 160); in general, "second marriages do worse" (Ibid.) according to American statistics; and close to one half of all marriages end in divorce according to Canadian statistics. These facts can be viewed as warnings that must be heeded. For those individuals who are considering forming a dyadic union, for those who have ended an intimate relationship and are beginning another, and for those single individuals who are pondering the staggering statistics and seeking hope and promise for a long-lasting, happy, and fulfilling romantic relationship, as well as for those practitioners who seek to help them, the psychoanalytic paradigm is useful as a framework within which to explore and understand how the past influences the present, and how new insight, understanding, and change can lead to healthier functioning and a more fulfilling romantic relationship. The psychoanalytic paradigm can be described well by the wise words of Santayana (1905) who stated that, "Progress, far from consisting in change, depends on retentiveness...Those who cannot remember the past are condemned to repeat it."

Within the psychoanalytic paradigm, couples are made aware of the significant impact their past experience has had and continues to have on their unconscious, and how their unconscious longings and desires are impacting upon their own functioning as individuals and as partners within their dyadic relationship in the present. It is important for individuals and for couples to

consciously resolve unconscious memories from the past, to overcome the hidden issues and conflicts from the past, and to develop healthier and happier patterns of functioning for themselves and for their partner, in order to ensure a newer, better, and brighter future that is no longer repeated but rather, begun anew. Once partners learn to "work through" and overcome their past, they can learn and integrate more functional ways of relating as individuals and as partners within their couple system, in order to experience and maintain a happier and healthier future.

Sections 2.4 and 2.5, which follow, focus on the psychoanalytic paradigm and the object relations model (which is psychoanalytic), and Section 2.6 discusses the object relations model in its application to the treatment of couples. Section 2.7 describes the usefulness of transference and countertransference as efficacious therapeutic tools within the psychoanalytic paradigm, and Section 2.8 details how practitioners who treat couples can apply these concepts as therapeutic tools to help individuals to uncover memories and experiences from the past, learn from these past memories and earlier experiences through therapeutic reenactment in the present, and then engage in a relearning of healthier patterns of functioning individually and dyadically, in the present and for the future.

In summary, the following has been outlined here: an accurate definition of romantic love, its meaning and implications for both the individual on an intrapsychic level and for the partners as a couple in interaction on an interpsychic level, an understanding of how individuals "fall" into the state of love unconsciously from the psychoanalytic perspective, and a better understanding of the unconscious mechanisms that motivate individuals to connect with others within an intimate relationship where they naturally bond as a couple, both consciously and unconsciously. The reader has also been provided with a preliminary understanding of how the therapeutic bond that is formed between couples therapist and couple triadically within the psychoanalytic paradigm can provide the foundation for the development and growth of healthier and happier functioning for the couple as they continue their dyadic dance together.

It is important for social work clinicians, researchers, and academics, as well as couples themselves to understand that the couple system is a unique entity in and of itself, with distinct dynamics and very special needs. The couple system has its own code of functioning, and each code is distinctive to each couple because each dyadic unit is comprised of two very different individuals attempting to come together, to "merge" as one whole entity. It is essential to realize that any couple staying the same will stagnate, and that a healthy couple is always in the process of growing and changing: a couple will achieve this objective (i.e. the knowledge acquired through insight and new understanding, and the learned skills required for healthy adaptability and effective communication) in therapy. It is also critically important for the couple to acknowledge change as a natural occurrence, where both the couples therapist and the therapeutic technique of psychoanalysis can facilitate this essential process. Within the psychoanalytic paradigm, couples are able to learn through emotional re-experiencing that change can be positive and growth-enhancing, and actually bring them closer together, rather than to be viewed as something negative and threatening, and something distressing to be feared.

The couple system changes in reaction to another change impacted upon the system (systems theory). Systems theory postulates this dynamic cycle on a systemic level, and self-perception theory (Bem, 1972) carries this into the realm of feelings where each person's feelings are in response to the other person, and one person's thoughts and feelings are impacted upon by the other's behaviours in the same way that one person's behaviours may be influenced by the other's thoughts and feelings. In the dyadic relationship or the couple system, each partner acts, reacts, and interacts in response to the other, both consciously and unconsciously. It is noteworthy that, through the examination of these dyadic dynamics, it can be clearly observed how the "other" to whom each partner is responding, is more in reaction to the significant "other" from the initial caregiving relationship in the past than to the present partner in the romantic relationship of the here-and-now. This is the premise of psychoanalytic theory. The couple system can be either challenged positively or threatened negatively by both internal and external pressures, and by

changes. In couples therapy within the psychoanalytic paradigm, the concepts of transference and countertransference may be effectively used as therapeutic tools to uncover the long- and deeply-embedded characteristics of both partners to explain their lack of adaptation to change and/or their inability to adjust to change in a healthy way. These therapeutic tools may also be used to help mates to better understand themselves and each other, to gain insight into the various changes within themselves internally and experienced externally, and to help them to successfully endure these changes as a dyad in order for them to continue to dance together as a couple, in harmony and through healthier and happier functioning.

In couples counselling, the tools of transference and countertransference may be used to trace the partners' present and past adjustment to change, and to facilitate their learning of new and healthier patterns of relating and communicating. Since the premise is that change is positive and growth-enhancing for a healthy couple, teaching partners to confront and manage change together would be even better. Couples are taught to welcome, accept, and adjust to change together as a dyad, and to replace their former fear, distress, and reactive conflict, which are dysfunctional responses transferred from childhood and from their earlier, formative years, with more functional coping mechanisms. Once couples learn that change can be positive, growth-enhancing, and intimacy-building for them as a dyad, and they are facilitated to relearn the functional behaviours, attitudes, and feelings requisite to attain and maintain these desired objectives in their relationship, couples can approach and adapt to change successfully.

Section 2.4: Review of the Literature: Theoretical Framework

The Psychoanalytic Paradigm

An Overview:

As previously discussed in Section 2.3, the increased rate of marriage breakdown and the consequent rate of divorce, as well as of dyadic breakdown and breakup in other types of couple relationships, call for an examination of significant causal factors and an exploration of the means

with which to better understand and treat couples as they confront difficulties; this can be achieved through continued research in the area of treating couples and improved methods for clinical practice in social work. As couple relationships continue to fail in their ability to thrive and grow, the need for effective couples counselling increases and the demand for answers and help from client couples directed to therapists also escalates.

While other social work models may be addressed, the main theoretical and clinical framework that has been selected as the most appropriate one for this research study is the psychoanalytic paradigm since it is within this particular paradigm that the natural phenomena of transference and countertransference are used as efficacious therapeutic tools in the exploration, diagnosis, assessment, and treatment of couples in therapy. Although the psychoanalytic model is viewed and applied most often in working with individual clients/patients, this model is very rarely considered or applied in couples treatment. However, this particular paradigm can also be an effective treatment modality in couples counselling, and the concepts of transference and countertransference found within this model can be viewed and used as indispensable components in the couple counselling context.

One of the unique tenets of the psychoanalytic paradigm is its ability to take the client/client couple back to childhood both on an unconscious and conscious level, enable him/her/them to understand the correlation between past functioning and present transactional patterns, and bring the partners to functional patterns as individuals and as individuals in interaction within the couple system, both in the present and in the future. The therapist is engaged with the dyad in couple therapy as both an observer and a participant within a therapeutic triad that dances a unique dance together, until the couple is facilitated to dyadically dance together on its own in a healthier and happier, mutually enhancing way. The psychoanalytic therapeutic process is a unique and intricate one of uncovering, discovering, and recovering that is accomplished through the exploration, revelation, and reparation of both unconscious and conscious functioning.

It is significant for practitioners who work within the psychoanalytic paradigm to note the main tenet that directs psychoanalytic practice. As Bettelheim (1982) states, "The guiding principle of psychoanalysis is that knowing oneself requires knowing also one's unconsciousness and dealing with it, so that its unrecognized pressures will not lead one to act in a way detrimental to oneself and others." (p. 24). The corollary of not knowing and understanding one's own needs and resolving them in a healthy manner is harmful not only to oneself but also detrimental to one's partner and to the dyadic relationship that two romantic partners share. The destructive effects that are turned toward the mate manifest themselves through dysfunctional communication and behavioural patterns.

In psychoanalysis, therapists facilitate and direct clients to engage in and have the experience of the intensive process of re-experiencing, examining, and understanding unconscious processes, since the premise is that, "...having one's sight turned away from the external world and directed inward - toward the inner nature of things - gives true knowledge and permits understanding of what is hidden and needs to be known." (Ibid). Through the psychoanalytic therapeutic process in couples' counselling, there is a focus on inner needs and feelings in order to not only help the individual partner to better understand him/herself, but to also help him/her better understand and relate to his/her partner.

The application of a psychoanalytic perspective in therapy focuses on the examination of, "...early learnings, to exploring the unconscious processes that underlie the here-and-now relationships...and that lead back to primary and primitive family experiences." (Moursund, 1990, p. 144). There are many issues left over from childhood that are later replayed in the individual's interpersonal relationships in adulthood, especially within the intimate relationship shared with the mate. "All adult relationships are, in one way or another, derived from early family relationships. After all, that is where we first learn that other people do exist and that we have to discover ways of getting along with them." (Ibid, p. 144). The unique and beneficial effect of the psychoanalytic paradigm and its use of transference and countertransference in the

intricate process of uncovering, discovering, and healing in couples therapy, is two-fold: the partners, as two individual partners and as a dyad, are given the opportunity within the therapeutic triad to re-create and re-experience dysfunctional relationship patterns from their respective pasts as two separate individuals that they are reenacting as a couple in the present, and the therapist has the opportunity to offer feedback, confrontation, and support to explore the maladaptive patterns and to integrate newly learned, functional ones.

The inner conflicts that partners struggle with on their own and that manifest themselves within the couple's relationship frequently have their roots in childhood, and need to be worked through in the protective refuge of the therapeutic setting. It is within the therapeutic context that partners are facilitated to explore and understand with new insight, the origins of the dysfunctional patterns as well as how these patterns are being replayed in adulthood, both consciously and unconsciously. The emotional experience of the past through a re-creation in the present is potentially curative, according to the premise of therapy that is based on psychoanalytic theory. The psychoanalytic theoretical framework is unique in its capacity to direct the therapist as he/she formulates the necessary steps to create the therapeutic setting that will allow for this re-dramatization to take place, and the opportunity for the old drama to be played out again but with the realistic expectation of a happier ending. The psychoanalytic model provides the therapeutic setting, the facilitator, and the opportunity for change on both an intrapsychic and interpsychic level; this model also offers the appropriate technique and efficacious tools to effect the desired change and the happier outcome. Responding through imitation or with newly learned skills of relating can be both powerful and empowering to the partners as individuals as well as to the couple in therapy, as newly acquired insights and well-incorporated skills that they can continue to carry with them beyond therapy and throughout their life. (Moursund, 1990). It is the psychoanalytic therapeutic setting that allows for the intense expression of maladaptive behaviours and other dysfunctional relational patterns; the exploration, interpretation, and understanding of these unhealthy patterns; and then the experiences of emotional learning to

occur in a corrective way. Yalom (1985) discusses this therapeutic process as a combination of catharsis and corrective emotional experience. (in Moursund, 1990).

Epstein and Feiner (1979) maintain that, "The focus in couple therapy is on the relationship between various feeling states and between subjects and objects, and on the manner in which these relationships are satisfying or not." (p. 179). Strean (1993) emphasizes that, "...effective therapy necessitates that the client be helped to feel and express a whole range of affects in the treatment." (p. 193). Scharff and Scharff (1991), well known for their work in counselling couples, summarize the objective of couple therapy within the psychoanalytic paradigm when they state that, "Our aim is to join patients at the level of their unconscious experience and then to relate to them through interpretive work based on our understanding of it." (p. 13). It is significant to note that all of these clinical objectives may be accomplished through the conscious and competent use of transference and countertransference. These concepts will be highlighted and discussed in further detail in Section 2.7, Transference and Countertransference, and their application to couples counselling will be presented in Section 2.8, The Role of Transference and Countertransference in Couples Treatment.

As stated earlier, transference and countertransference are natural phenomena that are ubiquitous. Transference is always present in *every* relationship. Countertransference is always found in the *therapeutic* relationship. It is this researcher's contention that when these phenomena are accurately viewed and understood as therapeutic concepts that may be applied effectively in the diagnosis and assessment of couples within the therapeutic relationship, an ongoing awareness of and an attention to them can continue to inform a smooth transition into the treatment phase of the therapeutic process. The conscious and competent use of transference and countertransference is critical to the appropriate application of psychoanalytic theory to couples therapy. These concepts are essential elements of the therapeutic process that provide insight, understanding, and corrective change to the individual mates intrapsychically and to the couple

system interpsychically. The awareness, acknowledgment, and use of these concepts as therapeutic tools by therapists in working with couples, is the focus of this research study.

Section 2.5: Theoretical Framework:

The Psychoanalytic Model and Its Application to Couples Counselling

This research study focuses on the knowledge base and clinical techniques of social work practitioners and other therapists who treat couples, and it is predicated on existing psychoanalytic theory that emphasizes the significance of both conscious and unconscious motivations. The psychoanalytic paradigm is highlighted as the general theoretical framework from which practitioners can draw as both a model of understanding and a model of intervention in working with couples. Contemporary psychoanalytic theory is pluralistic; it is characterized by multiple models. Some of these models retain Freud's drive theory; others, such as object relations theory, replace or reduce the centrality of sex and aggression, and instead emphasize the relationship as central to both personality development and therapeutic intervention. However, all psychoanalytic models, regardless of important differences, view transference as the central treatment concept. The tenets of psychoanalytic theory are founded upon the careful, intensive, and extensive exploration of the self and the self-in-relation-to-other. The object relations model, which emphasizes the two-person relational connection, thus appears to be the most appropriate and accurate model for understanding and intervention in relation to couples therapy, and it has been selected as the most useful psychoanalytic framework within which to conduct this study. "Object relations psychotherapy is psychoanalytic in that it is interpretive rather than instructive. It focuses on unconscious processes that occur both within and between each member of the couple." (Frank, as cited in J. S. Scharff, 1991, p. 177). (The object relations model and its application to couples therapy is presented in further detail in Section 2.6, The Object Relations Model and its Application to Couples Counselling). Transference and countertransference (i.e. the therapist's transference) will later be discussed as central concepts to the object relational model, which can be applied as efficacious therapeutic tools in the treatment of couples.

On a very basic level, **psychoanalysis** can be accurately defined as the deliberate, careful, and conscientious analysis of the psyche, through an intensive exploration of the processes of the unconscious. The Concise Oxford Dictionary of Current English (1964) defines **psychoanalysis** as, "the psychology of Freud, Jung, and Adler, dividing the mind into conscious and unconscious elements, and investigating the interactions of these" (p. 988), and Webster's Dictionary (1972) further describes **psychoanalysis** as, the "technical procedure for investigating unconscious mental processes and for treating psychoneuroses." The purpose of therapy based on this paradigm is to improve the functioning of the self of the individual on an intrapsychic level through the intensive examination of unconscious processes; where there are two mates in interaction, the purpose is to facilitate their connection as a couple system on an interpsychic level. This latter objective of improving the connection of the two partners as a couple system is accomplished through "the joining of their unconscious processes", a psychoanalytic therapeutic technique that is applied in couples therapy, to provide increased insight for each partner into his/her mate and to promote empathy for each other, and to thus enhance their functioning as a dyad. This "joining" process refers to the therapeutic technique involved in the attainment of a shared understanding through interpretations of transference to each other and to the therapist. From a two-person relational perspective, the emphasis is on the relational aspects of the self; specifically, the connectedness with others. The direct focus is on the intrapsychic dynamics of the self of each individual, as well as on the interpsychic dynamics at play within the dyadic interaction of the two selves of the partners within the couple system.

Within the context of counselling for the complex couple system, the therapist is faced with a challenging clinical dilemma that must be identified, accepted, and managed. Each partner within the dyad or couple system has his/her own history, past experience, and earlier significant others which he/she brings both consciously and unconsciously to the romantic/love relationship. These overt and latent needs, desires, and emotions will manifest themselves in the actions extended toward the partner as well as the reactions that occur in response to the mate, as a result

of current or past difficulties. It is clear that there is a strong connection between psychoanalytic theory and attachment theory (which is relevant to the treatment of couples, and can be classified as a psychoanalytic one) since the premise of attachment theory (Bowlby, 1969) is that the type of attachment (i.e. secure or insecure) formed in the initial infant-caregiver relationship influences the type of interpersonal relationship that the individual will later experience in adulthood, especially within the intimate relationship shared with the significant other or his/her mate. Psychoanalytic theory can be used to trace back to the type of attachment that was formed in the past, and in this way, explicate the attachment of the current couple system. As Scharff and Scharff (1991) point out, "Fairbairn (1952, 1963) saw infants as 'object-seeking', compelled to reach for a relationship with their mothers so that their fundamental needs for attachment and nurturance could be met". (p. 44). According to Fairbairn's psychoanalytic theory, "When innate strivings for interaction, especially those based on incorporative wishes, were not lovingly responded to, these infants came to feel their love was bad or worthless." (Moore & Fine, 1990, p. 71). How the individual views him/herself and others, the feelings evoked within him/her in his/her relationships with others, and the way(s) in which the individual gives, receives, and experiences love in his/her romantic relationship with his/her partner, are all influenced by unconscious thought and affective processes that were developed in infancy and continue to exert their impact in the present.

Psychoanalytic theory is predicated on the principle that most conflicts that occur between romantic partners are rooted in conflicts originating within each partner's past relationships within his/her family of origin, in reaction to a significant figure from the past or a previous meaningful experience connected to a significant person from the past. This previous experience can be either negative or positive. Partners are reacting to each other in the present but in reality, they are reenacting on an unconscious level, to an issue related to someone or something from their past. Psychoanalytic theory (Freud, 1910, 1912) posits that personal (intrapsychic) and interpersonal (interpsychic) difficulties that are conceived in our earliest relationships resurface in

later relationships with significant others, and that these painful symptoms can be alleviated and the continual suffering finally ended within these same relationships. As well, the dysfunctional patterns revealed within the self and within the relationship shared by the selves of both partners can be replaced with healthier and happier functioning. While attachment theory is relevant to couples therapy, it was Freud's drive theory that originated the concepts of transference and countertransference. Freud postulated that transference may be used to trace back to the type of attachment that was initially formed and existed in the past, but which is still having significant implications in the present. The premise of psychoanalytic theory is that the intrapsychic and interpsychic experiences (both positive and negative) that are first encountered by the self of the individual in the early infant-caregiver relationship will reappear on both an unconscious and a conscious level in later relationships with significant others, including and particularly the romantic relationship shared with the mate. It is psychoanalytic theory that can assist therapists to trace back to the attachment patterns of each partner, as a means of further understanding their interpersonal dynamics within their dyadic relationship, and it is psychoanalytic theory that can also be used to explicate mates' present functioning and then to ameliorate it, both intrapsychically and interpsychically.

It is noteworthy that, "A positive intimate relationship provides a secure base (Bowlby), from which to face the world and is emerging as one of the primary determinants of physical and emotional health." (Johnson, 1991, p. 176). How securely attached or insecurely attached an individual is, is the main determining factor in his/her choice of a romantic partner and his/her expectations of that partner as well as the way in which he/she will treat the partner.

It is important to note that, "...the failure to develop a satisfying intimate relationship with one's partner is now the single most frequently presented problem in therapy." (Horowitz, as cited in Johnson, 1991, p. 176). The security provided and experienced, or withheld in infancy and childhood, will be sought in the romantic relationship in an attempt to "mirror" or "fix" the relationship from the past through the present relationship with the mate. An absence or a taking

away of the safety and security needed and desired in childhood will resurface unconsciously in adulthood, with realistic and often unrealistic expectations placed upon the mate, through projections, for provision of what was "missed", and a feeling of resentment and aggression if the response of the mate is not the desired one. If the mate says, does, or acts in any way that triggers an unconscious response in the other that he/she is being unloved, not cared about, or neglected, the old ghosts from the past reappear in the present form of the mate, and the old drama with the old patterns are replayed, with the same ending. "As the drama unfolds in many of these relationships, there is the desire for a new ending. This circular, repetitive behavior becomes very intense, and since conflicts unfortunately do not get resolved through repetition, they often end in frustration and rage." (Lachkar, 1992, p. 44).

Often, the secure base that is essential and unconsciously longed for, and which is also the measure of a healthy, functioning self, is provided for the individuals for the very first time within the psychoanalytic therapeutic setting, where there is a safe and secure atmosphere for (1) the requisite open and honest sharing to take place, (2) a reenactment of the dysfunctional behaviours and negative communication patterns to be played out, and (3) the opportunity exists for newer, healthier, relational transactions to be learned and practised, as well as (4) the chance for the old wounds to finally be healed.

As Lachkar (1992) points out, "Aggression gets confused with real needs for love, affection, time, and attention...the therapist must take the focus of the aggression and get to the legitimacy of needs and entitlement." (p. 45), and within the safety and security of the therapeutic alliance and the therapeutic setting, "...possibilities emerge from a relationship to be discovered, cultivated, respected, and enhanced by the marital therapist." (Kershaw, 1992, p. 136). Brothers (1992) emphasizes that, "Couples in conflict are better able to join with therapists who can provide therapeutic alliances (attachments) that constitute a secure base from which they can explore their anxieties, fears, and relational dynamics" (p. 79), and Lachkar (1992) states that, "The therapist must be available for the play in order for the drama to unfold..." (p. 58). It is

clear that the couples therapist must be both physically and emotionally present for both partners as individuals and as a couple, in order to provide the availability, accessibility, and provision of safety, security, sensitivity, empathy, acceptance, and understanding that may have been "missed" or lacking, or dysfunctionally extended to the individual in his/her earliest relationship from infancy and childhood. Since, from the psychoanalytic perspective, there is the view of "...successful therapy as a *corrective emotional experience*" (Alexander & French, as cited in Kahn, 1997, p. 99), the provision of essential past needs, including a secure base, must be extended to the couple in the therapeutic setting, and this secure base must be something that they learn about and acquire through therapy and through the therapist, in order for the partners to later be able to provide this secure base for themselves and for each other within their relationship in the future.

Psychoanalytic theory postulates that the individual attempts to seek fulfilment through the intimate relationship with his/her mate. Frank (1991) maintains that there are two types of marriages that occur; the first type "aimed at conserving idealized images" (as cited in Scharff, J. S. 1991, p. 176) from the past, and the second type in which, "the couple marries to resolve past unconscious conflicts through repetition in the present." (Ibid.).

In addition to his/her own needs, desires, and feelings as an individual who is functioning in unconscious reaction to the personal history that he/she brings from the past to the present intimate love relationship, there are also current concerns, issues, needs, and desires to be addressed and resolved that are specific to, as well as shared with the other mate as part of a couple. Dicks (1967) emphasized, "the importance of grasping the meaning of unconscious communications as the essential part of marital therapy worthy of the name" (p. 118). The therapist needs to be aware of in vivo conflicts and their relationship to conflicts stemming from the past. The couple's distinctive attributes may result from the partners' frequently shared attempts to reenact past themes and/or conflictual experiences from a specific early childhood

stage in the development of self and object relations (Dicks). A more detailed discussion of the object relations follows, in the next section (2.6).

It is important to distinguish the main difference between the classical and relational models of psychoanalytic theory, prior to outlining the object relations model and its application to the treatment of couples. In reviewing the literature, contemporary object relations and self psychology are considered to be the most applicable models for understanding and treating couples due to their emphasis on both intrapsychic and interpsychic dynamics. Classical theory and classical self psychology are each considered to be a one-person psychology since both theories have a focus predominantly on *intrapsychic* dynamics (i.e. Kohut, 1977, 1984; Goldberg, 1986, 1987). Object relations and self psychology are both models that emphasize a two-person definition of the self where the focus is on the relational component.

Section 2.6 The Object Relations Model and its Application to Couples Counselling:

The object relations model, by way of contrast with classical theory and classical self psychology, is a two-person psychology or a relational theory, which emphasizes *interpersonal* dynamics. Within object relations theory the central focus is on the self-in-relation-to-other. The intrapsychic dynamics of the individual partners as well as the intersubjective dynamics of the couple system are explored as crucial components for the change process. As J. P. Siegel (1992) maintains, in couple systems, "The reparation of intimacy calls for an appreciation of intrapsychic as well as interpersonal dynamics" (p. 4), and in the context of couples counselling, "Marital dynamics cannot be understood without recognition of how spouses perceive, interpret, and attach meaning to their interaction." (Ibid., p. 4). It is important to note that each partner's perceptions and interpretations concerning various actions and/or specific situations that arise are not neutrally determined, but instead based on, "the expectations and subjective, intrapsychically determined perspective of each." (Ibid.). As previously stated, the psychic structure that is developed within the individual is a result of the type of initial caregiving relationship that the

infant experienced with his/her mother. (Fairbairn, in Scharff & Scharff, 1991). The initial mother-infant relationship influences how infants see themselves and others, and these perceptions and feelings are carried over into adulthood in terms of the self in-relation-to-other. As Scharff and Scharff (1991) explain,

> Feelings of need or frustration color the infant's appreciation of actual events. This mixture of experience, affect, perception, and misconception not only affects the experience and the child's memory of events but, much more important, it determines the child's psychic structure. This structure is seen as one consisting of a system of conscious and unconscious object relationships that crystallize out of the infant's experience of real relationships. (p. 44).

Scharff and Scharff (1991) view the object relations model as the most applicable theoretical framework in which to understand and treat couples since this model focuses on both the past and present functioning of each partner on an intrapsychic level, as well as their dyadic functioning in the past and present on an interpsychic level. The couple needs to be viewed as two separate individuals in interaction as well as one single systemic entity. J. P. Siegel (1992) maintains that, "The spouses' capacity for intimacy and the ways in which partners are used to fill emotional needs are similarly determined by intrapsychic phenomena. For these reasons, marital therapy must address individual as well as systemic dynamics." (Ibid.)

As previously outlined, Fairbairn's (1952, 1963) focus was on the "object-seeking" self and the importance of internalized (object) relationships that impact upon the later relationship shared by partners. While object relations theory is generally considered to be, "...an amalgam of the theories of a number of independent British thinkers: Fairbairn, Guntrip, Balint, and Winnicott" (Scharff & Scharff, 1991, p. 43), nevertheless, "...their work is generally recognized as influenced by Klein..." (Ibid.). According to Scharff and Scharff, "...Klein's concept of projective identification (1946) provides the necessary bridging concept to extend the individual psychology of object relations to the interpersonal situation." (pp. 43 - 44). Moore and Fine (1990) point out that, "Melanie Klein, whose work greatly influenced Fairbairn, postulated a critical first structural

achievement whereby the infant could preserve his or her internalized mother as a whole person from the destructive impulses of the death instinct." (p. 71). Moore and Fine maintain that from this, "Fairbairn concluded that an essential prerequisite for what Klein described involved gaining a structured security within the self from which to relate to the good mother." (Ibid.). In contrast to Freud, "Fairbairn regarded failure in...developmental functions..." (Ibid) as one of the "...ultimate disasters that could threaten the ego" (Ibid.). Fairbairn did not concur with Klein's concept of the death instinct; instead, Fairbairn emphasized, "...environmental factors – namely, the quality of the mother's loving care – as crucial to early development." (Ibid.)

It is noteworthy that, "Fairbairn concluded that the libido theory should be replaced by one founded on purely psychological factors in the relations with the other and later the father, not on hypothetical instinctual energies and the zonal discharge of tension." (Moore & Fine, 1990, p. 71). In contrast to Freud, "...Fairbairn asserted that psychoanalysts' fundamental concern was not the vicissitudes of instinct but events within relationships of dependence on others, without which there could be no development." (Ibid.) Scharff and Scharff (1991) assert that, "The individual personality, composed of a system of parts, some conscious and some unconscious, is in dynamic relation to the family system and its parts and to the individual members an their personality parts." (p. 44). Scharff and Scharff explain that, "The resulting personality is complex, reflecting multiple identifications and counteridentifications with parts of others, organized in conscious and unconscious areas of the personality." (Ibid.) As stated by Moore and Fine (1990), "His clinical observations led Fairbairn to develop what he called an *object relations theory of the personality*" (p. 71), and, "This reinterpretation of psychoanalysis had two substantial departures from Freud." (Ibid.). While Fairbairn further developed his own object relations theory from classical Freudian theory, there were the two major distinctions or departures from Freudian theory. "First, Fairbairn conceived of the ego as a structure present from birth rather than developed from the id as a result of its relations with reality. The ego had an energy of its own, not acquired from the id; it was a dynamic structure." (Ibid). Secondly,

while, "...he retained the term *libido*" (Ibid) to refer to energy, nevertheless, "Fairbairn's libido is object-seeking, not pleasure-seeking; its aim is not the relief of tension but the establishment of satisfactory relationships." (Ibid.)

Based on Fairbairn's theory of object relations, the individual is motivated to seek a relationship with an object from infancy through adulthood; this concept can readily be applied to the couple context. In their explanation of Fairbairn's theory of object relations, Moore and Fine (1990) state that, "Itself a source of energy, the ego is from the start oriented toward reality, seeking a relationship with a primal object, the breast or mother." (p. 72), and, "The structure of the mind develops from this pristine ego through the processes of internalization, splitting, and subsequently repression of the maternal object." (Ibid.). As stated by Moore and Fine,

> Necessary dissatisfactions and frustrations in the relationship between mother and infant, especially those activated by separations, result in the internalization of an object which is both satisfying and unsatisfying. The infant's response is ambivalent, anxiety is evoked, the sense of security is disturbed, and defensive operations are elicited. (p. 73)

These early developments in object relations for the infant will be carried over into adulthood, and again occur within the intimate relationship shared with the mate. "Kernberg (1985) suggests that many of these internalized, unconscious aspects of the primitive self are completely split off the adult's awareness but may become activated through adult experiences that rekindle the memory traces" (as cited in J. P. Siegel, 1992, p. 18). According to J. P. Siegel (1992), "Intimacy activates self representations that are not typically experienced in other situations or interpersonal interactions." (p. 18). Within the intimacy of the romantic relationship shared by mates as a couple system, "A new identity is created as the self is experienced as a loved object, a sexual object, a loving and dependent self, and a partner in a relationship that causes the self to be redefined by others." (Ibid.). Within the couple relationship, "As previously unknown or split-off aspects of the representational world are brought into awareness, each partner in the relationship must struggle to accept the emerging aspects of the intimate self." (Ibid.).

Fairbairn referred to "splitting" as, "...a universal mental phenomenon necessary to cope with the frustration and overexcitement of early human relationships..." (Moore & Fine, 1990, p. 72), and considered this to be, "...a normative (although sometimes pathological) defense mechanism that divides and organizes the ego (self)." (Ibid.). According to Fairbairn's theory, "Objectionable aspects of the object are split off and repressed, constituting an internal world. Some internal objects represent whole persons..." (Ibid), and other parts of objects or parts of persons. "These whole or part objects can be repressed or projected onto outside objects." (Ibid). The representational world, as it has been developed in infancy, becomes the internalized or inner world of that individual, and greatly influences how he/she will view and experience his/her mate, as well as his/her relationship with the mate. J. P. Siegel (1992) maintains that, "The content of the representational world influences intimacy in many ways." (p. 18). According to J. P. Siegel, "...identity is sharply altered as aspects of the representational world come into awareness. Experiencing the self as a loved object may revive infantilized desires and disappointments that have long been repressed. The experience of self as a sexual object may revive similarly repressed yearnings that may create considerable anxiety or cause a conflict with prohibitive superego introjects." (pp. 18-19).

As Moore and Fine (1990) affirm, "Fairbairn conceived of the ego as attached libidinally to objects; hence the splitting of the object involves the splitting of the parts." (p. 72). It is important to note that, "The original love object receives the infant's love and hate", as the infant experiences the "ideal object" or "accepted (ideal) object" that is initially internalized as pleasing and comforting, the "exciting object" that is experienced as the appealing and tempting whole or part object, and the "rejecting object" that experienced as a frustrating and withholding whole or part-object. (Moore & Fine, 1990). The infant's experience on an unconscious level of "good objects" and "bad objects" is internalized and becomes the individual's representational world. As stated earlier, within the intimate relationship shared by mates, these earlier representations are revived. (Siegel, J. P., 1992). As J. P. Siegel notes,

> The experience of self as dependent usually provokes strong reactions, as aspects of earlier dependencies are revived. Fears of engulfment, of losing the self, or of being controlled may lead to self-protective ruptures in intimacy and increased differentiation. Similarly, the experience of self as loving evokes a sense of responsibility that may revive earlier resentment and fear of further attachment. (p. 19).

The therapist working within the object relations framework has a means with which to acquire insight for him/herself as well as for the partners, into how each partner's past object relations experience and internalization are currently contributing to the dyadic relationship, on both an unconscious and a conscious level. "Object relations theory provides an explanation of the ways in which the subjective and external worlds are linked," (Siegel, J. P., 1992, p. 4), and, "By drawing upon object relations concepts, the couples therapist is able to comprehend both the intrapsychic and interpersonal. Knowledge of one area refines the therapist's understanding of the other." (Ibid.). This understanding with new insight can be extended to both partners, to promote a greater sensitivity and empathy, and a newly shared view into their functioning as a couple system.

The intimacy involved in a romantic relationship, as well as the nature of this type of relationship, evoke feelings and perceptions within the individual that have been previously developed in infancy. How the individual sees him/herself as well as the ways in which others view him/her, "may create a validation of self that revives affirming representations, but may also raise fears of inadequacy as the self faces further evaluation and appraisal from others." (Siegel, J. P., 1992, p. 19). As J. P. Siegel explains,

> The expectations and ego ideals that have been split off from awareness surface with surprising intensity and create self-scrutiny and careful evaluation of the new loved object. Issues of adequacy surface when the self is viewed as an extension of the self. (Ibid.).

It is noteworthy that, "Because the intimate self is gender specific, intimacy may revive an identification with the same-sex parent that has been previously repressed or denied." (Siegel, J.

P., 1992, p. 19). As J. P. Siegel explains, "The acceptance of the role of the husband, for example, creates an immediate identification with the husband in the child's family of origin. If that identification has been shunned, the reawakened identification will provoke discomfort and anxiety." (Ibid.).

The focus of the object relations model, when treating couples, is on understanding and developing insight into the unconscious processes of both partners in order to facilitate a healthier dyadic relationship based on mutual fulfilment of needs, desires, and wishes. Epstein and Feiner (1979) describe the purpose of "couple therapy" where, "the content of interventions is...aimed at interpreting and working through unconscious issues interfering with conscious efforts to sustain a mutually satisfying and growth-promoting relationship." (p. 184).

It is significant that, "successful treatment of couple relationships depends on diagnosis of the couple's developmental mode of object relations." (Sharpe, as cited in Solomon & Siegel, 1997, p. 70). The model of object relations provides both insight and understanding for the couple's current functioning, as well as intervention through an exploration of their past and present object needs and desires. An understanding of the couple's present relational model can be attained through an examination of each individual partner's object relations set as it was developed in their past and their current object relations set as a dyad. Through the application of this model to couples treatment, each mate is made aware of his/her own object needs as well as those of his/her partner, and introduced to a healthier mode for responding to these object needs through a shared reciprocity.

> In marriages that work, the partners have learned to understand and respond to each other's underlying needs in a mutual exchange without either one's feeling diminished. Each uses the other at times as an "object" for restoration, consolidation, transformation and organization of internal experiences in order to maintain or regain feelings of cohesiveness.
>
> (Solomon, 1989, p. 25).

In couples treatment where the object relations model is applied, couples gain an awareness that they did not previously have, in terms of their own needs, desires, and functioning as well as those of the mate. The model of object relations is helpful in guiding couples to an understanding of their own intrapsychic functioning as individuals, and how this affects the way in which they perceive and thus treat their mate. Instead of one partner placing responsibility or blame on the other, he/she can now look at him/herself and ask, "How much of this (i.e. what is going on) has to do with *me*?"

As Scharff and Scharff (1995) assert, the object relations model is also valuable in couples counselling since its focus is on both the here-and-now and the past. The strength of this specific therapy in working with couples is that, "the here-and-now is connected to its roots in the past." (p. 65). Partners are facilitated to understand their present intrapsychic and interpersonal functioning as a consequence of each individual partner's past. As J. P. Siegel (1992) states, "...the couple cannot be understood without appreciation of each spouse's intrapsychic structure, historically determined intimacy needs, and specific projective identifications..." (p. 59). In object relations therapy with couples,

> Previous experience is re-created in the here-and-now. In object relations, that connection has to be made. The unconscious influence of previous experience can be made conscious, so that a person can have control over current behavior and ways of relating. (Ibid., p. 65).

The therapeutic relationship that the client couple forms with the therapist is frequently a mirror of the couple's own relationship, which includes their specific relational mode. Scharff and Scharff (1995) assert that, in object relations therapy, "The patient (or the group of patients when we see a family, couple or therapy group) establishes a current relationship with the therapist that reflects the internal objects relations set that is brought to all relationships." (p. 52). When applying the object relational model to couples work, the therapist takes on the role of active participant in the therapeutic process, and his/her subjective thoughts and feelings, as well

as those of the client/client couple are considered to be important and integral components in the process. "In therapy, we take it as our task to experience these current expressions of object relationships in the interpersonal field." (Ibid., p. 52).

The therapist and client/client couple are partners in the therapeutic relationship; they have the mutual objectives of gaining insight into and understanding of the client's internal world and the client couple's shared mode of relating, which is a manifestation of each partner's internal world in combination with that of the other partner. Within the therapeutic relationship shared by therapist and client couple, "the patient and the therapist join together in the task of examining the patient's internal world and its effect on the patient's relationships..." (Scharff & Scharff, 1995, p. 51). The therapeutic relationship, as experienced by the therapist, is viewed and used as a source of data to help inform both therapist and client couple about the couple's current relationship. "As the therapist processes the experience of this current relationship, he or she is able to inform about this experience. In this way, patient and therapist have a current shared relationship that both can study and learn from." (p. 52)

It is relevant that, "Object relations concepts have been used to shape family and marital therapy for the past thirty years." (Siegel, J. P., 1992, p. 4). As noted by J. P. Siegel, "Recent contributions to the field of object relations family therapy by American therapists have expanded clinical understanding of the dynamics that link internalized and actual family relations." (p. 5). Research studies (Shapiro et al., 1997; Zinner & Shapiro, 1972, 1975, in J. P. Siegel, 1992) have demonstrated how internalized family-of-origin dynamics re-emerge as internalized object relations in present family relationships and the interpersonal dynamics found within them. In clinical treatment of couples, the internalized object relations of individual partners resurface within their shared dyadic relationship, and in family therapy, earlier object relations can be examined to explain and elucidate current interpersonal dynamics between family members. (Scharff, J. S., 1989; Scharff & Scharff, 1987, 1991).

The relevance of understanding the object relations set of each partner to couples counselling is clear; how each partner views and experiences self will determine how he/she views and experiences the other and their relationship as a couple. As J. P. Siegel (1992) states,

> Together, the structure, functions, and content of the representational world determine each spouse's subjective experience of self as well as the subjective evaluation of the marital relationship. Each spouse's capacity for dependency and trust can similarly be traced to the expectations of self and others that are encoded in internalized object relations. (p. 7).

Noteworthy is that in couples work, the examination of intrapsychic and interpersonal dynamics as well as the exploration of the past as a way of understanding and improving present functioning are invaluable elements of the therapeutic process that provide a comprehensive picture for both therapist and couple. The object relations model, with its emphasis on both intrapsychic and interpsychic dynamics, and its focus on the past as well as the present, extends an effective framework for understanding and treatment to the therapist who works with couples.

> The conflict, emotional pain and ruptures in intimacy that lead couples to marital treatment are as much a property of the intrapsychic representational world as of the relationship itself. Past and present, intrapsychic and interpersonal are linked through the representational world. The therapist who is able to assess and intervene accordingly is best able to engage the couple and provide a specific and meaningful marital therapy. (Siegel, J. P., 1992, p. 7).

Unconscious motivations are also examined as crucial components for the corrective emotional process to be successful. The unconscious motivations of transference are natural phenomena that are always present within the couple relationship, just as transference and countertransference are always present within the treatment relationship. Within the therapeutic setting, these phenomena may be used as therapeutic tools in the intricate process of uncovering, discovering, and recovering for couples as individual partners and as a couple. As Scharff and

Scharff (1995) assert, "Transference and countertransference are central to the technique of object relations therapy. They provide a workable, current version of the patient's object relations as lived out in the relationship with the therapist." (p. 112). Scharff and Scharff refer to this clinical situation as "the here-and-now, where the internal object relations can be felt and lived out and thereby understood – rather than simply talked about intellectually". (Ibid.).

Transference and countertransference are psychoanalytic concepts found within the object relational model, which may be viewed and used as indispensable therapeutic tools in the intricate peeling, revealing, and healing process of couples treatment. These tools have the capacity to not only peel back the multiple layers of unconscious functioning of the individual partners to reveal the roots of each partner's object needs and their shared "objects set" as a couple, but when applied appropriately, these tools help partners to recover and heal.

The concepts of transference and countertransference and their historical development will be presented in the following section (Section 2.7, Transference and Countertransference), and the application of these concepts to couples counselling will be discussed in further detail in the subsequent section (Section 2.8, The Role of Transference and Countertransference in Couples Treatment).

2.7 Transference and Countertransference

Awareness of transference and countertransference in the therapeutic relationship can be used to (1) uncover and clarify the dynamics of couples, whether functional or dysfunctional, to (2) discover the roots of the dysfunction, and to (3) help partners discover newer, healthier forms of communication and relating as a couple, and then finally, to (4) help the partners of the dyad as they recover and heal in their enhanced relationship. It is important to define and better understand these natural phenomena that can be perceived and applied as efficacious therapeutic tools.

Essentially, within the therapeutic context, the term **transference** refers to the client's/client reactions to the therapist, and the term **countertransference** refers to the therapist's reactions to the client(s)/client couple as individuals and/or as a couple. Shapiro (1995) offers an excellent definition of both **transference** and **countertransference**, in terms of their relevance to the therapeutic relationship. In conceptualizing these terms, it is important to consider the following:

> Traditionally, transference is defined as those feelings displaced from the past and projected in distorted fashion onto the analyst. Countertransference is defined as feelings from the analyst's past stirred up by the patient's transference reactions and projected onto the patient. Patients in analysis come to experience their analyst in ways that are similar to important past relationships, and analysts similarly come to experience their patients as they did important figures from their pasts. (p. 30).

Shapiro (1995) also offers the following definitions of these essential components of psychoanalytic therapy: "...**transference** as the patient's habitual way of organizing his experience of a relationship, including all the emotional feelings experienced by the patient to the therapist" (Stolorow & Lachmann, in Shapiro, p. 30), and "**countertransference** as all the ways in which the analyst experiences the patient." (Fossage, in Shapiro, p. 30).

Fiscalini (1995) defines **transference** as, "the unconscious transfer of experience from one interpersonal context to another. It refers, in other words, to the reliving of past interpersonal relations in current situations." (p. 1). This "reliving of past interpersonal relations in current situations" (Ibid.), and, "the corrective emotional experience" that Alexander and French (1946) speak of, can be attained through the intimacy and reenactment within dyadic relationships shared by mates, and within the triadic, therapeutic alliance with the therapist in the therapeutic setting, as long as healthier patterns of relating also occur and are integrated by the partners. Essentially, within the therapeutic context, the term transference refers to the client's/client couple's reactions that are being directed to the therapist, and the term countertransference refers to the therapist's reactions to the client(s)/client couple as individuals and/or as a couple.

As previously discussed, the healthy or unhealthy transactions between caregiver and infant begin in infancy, are reestablished in childhood, and later reenacted in adulthood in **transferential** relationships with significant others, especially one's mate, and also with a client's/client couple's therapist within the therapeutic relationship. J. S. Scharff (1991) maintains that, "Object relations theory was developed from the study of the experience of the early mother-infant relationship as it emerged in the transference in psychoanalysis," (p. 12), and that, "The transferences resulting from this period persist as potential or actual distortions of the present relationships among family members." (Ibid.). Scharff and Scharff (1995), in referring to their clinical treatment of individuals, couples, and families, state that, "...we work toward substituting conscious and more rational understanding for previously irrational behavior stemming from the primary process of the unconscious." (p. 18). Scharff and Scharff point out that, "Freud said that the goal of treatment is to make the unconscious conscious." (p. 18). Through the application of transference and countertransference, the unconscious processes are made conscious. Interpretation is an essential element of psychoanalytic therapy, through which transference and countertransference can be given new meaning and an understanding that can be shared with the patient or patient couple. Scharff and Scharff define interpretation as, "...a continuum of therapist interventions, from complex formulations that are mutative to simple comments, on the way to building shared understanding," (Ibid.) and they maintain that,

> Interpretation begins with linking and clarifying and proceeds all the way to understanding how whatever happened long ago in the patient's life influences current difficulties in relationships. The most effective interpretation begins with the current reenactment in the transference and countertransference and proceeds to the reconstruction of repressed internal object relationships. (p. 114).

Moore and Fine (1990) maintain that, "Transference is a type of object relationship, and insofar as every object relationship is a reediting of the first childhood attachments, transference

is ubiquitous." (p. 197). In psychoanalytic therapy, "...as analysis proceeds, the patient begins to tolerate the derivatives of childhood compromise formations that underlie transference." (Ibid.). It is noteworthy that, "...transference,...it came to include a variety of object-related activities which need not be repetitious of relationships to important figures in the past." (Sandler, as cited in Shapiro, 1995, p. 30). Shapiro (1995) distinguishes psychoanalysis as the therapeutic process where the analysis of transference is the focus, and psychotherapy as the therapeutic process where transference is carefully managed and manipulated by the therapist, as well as analyzed. Shapiro also maintains that through a process of "systemic investigation", the therapist needs to first examine his/her own feelings and how they contribute to the therapeutic relationship and process, and then explore the clients' other significant relationships in both the present and the past.

Transference refers to the feelings, thoughts, and behaviour that belong to the patient/patient couple and are usually unconscious, but manifest themselves in conscious functioning that may seem irrational, inexplicable, or inappropriate in the context of the current interpersonal experience. Moore and Fine (1990) affirm that, "Analysis and interpretation of the content of transference is central to the therapeutic process." (p. 197). Moore and Fine also point out that,

> Indeed, some analytic authors have stated that only transference interpretations are mutative. The transference may be appreciably modified in the course of treatment, but it is doubtful that it is completely resolved, or that such resolution is necessary for successful analysis. (Ibid).

It is evident that there is an ongoing debate concerning the usefulness of transference and countertransference, which will be discussed in detail within this section; however, the potency of these concepts as therapeutic tools is certainly evident. Lawrence (1999) maintains that, "...transference lies at the heart of psychoanalysis" (p. 6). Molnos (1995) maintains that, "...the other key ingredient that makes a therapy psychoanalytic: the transference (p. 32), and states that, "The most important thing that happens in the therapeutic situation is that we 'work in the transference' ". (Ibid., p. 32).

Countertransference refers to the feelings, thoughts, and behaviours that belong to the therapist within the therapeutic setting. These feelings, thoughts, and behaviours are unconscious, but are often manifested in conscious functioning. As Moore and Fine (1990) state, "Countertransference therefore reflects the analyst's own unconscious reaction to the patient, though some aspects may be conscious" (p. 47), and in this way, "The phenomenon is analogous to transference, which is of central therapeutic importance in analysis." (Ibid.). It is important to note that there are different perspectives of both transference and countertransference, in terms of their respective conceptual definitions and the theoretical and clinical implications of these varying definitions; this will be further discussed later within this section. Moore and Fine offer the following explanations of countertransference:

> Countertransference is narrowly defined as a specific reaction to the patient's transference. Others include all of the analyst's emotional reactions to the patient, conscious and unconscious, especially those that interfere with analytic understanding and technique. This broad purview might be better designated *counterreaction*. (Ibid.)

While there are varying definitions and meanings of transference and countertransference that are specific to their psychoanalytic paradigms and additionally, divergent perspectives of these concepts by practitioners, nevertheless transference and countertransference have the capacity to be potent therapeutic tools that can provide critical cues for both pracititioners and the client/client couples whom they treat.

Sharpe refers to transference and countertransference as the "most valuable of therapeutic tools" (as cited in Solomon & Siegel, 1997, p. 70) that assist the couples therapist as he/she is given "the facility of being able to dance in and out of the couple system, in and out of countertransference enactments" (Ibid., pp. 70-71) to better develop the requisite understanding, insight and shared communication for both therapist and dyadic partners. Renik (1993b) refers to countertransference enactments as "the vehicle" by which therapists are able to identify their own countertransference. It is essential for the therapist to be able to identify those counter-

transference reactions that are elicited by the couple and may be used therapeutically to help the clients/client couple, and those countertransference reactions that may belong to the therapist.

Scharff and Scharff (1995) assert that, in terms of countertransferential effect, "...the therapist will examine them thoughtfully as the best set of clues as to the patient's problems in relating in depth, and will then use the countertransference to inform the ensuing interpretation of the transference. (p. 53).

Moore and Fine (1990) emphasize that there has been, and continues to be opposing views regarding the use of countertransference. There is the possibility that the countertransference "...can impede the analyst's neutrality, leading to 'blind spots' that impair empathy and understanding; or in extreme cases, countertransference may lead to acting out." (p. 47). However, Moore and Fine also point out that, "On the other hand, the analyst's scrutiny of countertransference feelings can provide clues to the meaning of the patient's behavior, feelings, and thoughts, thus facilitating perception of the patient's unconscious." (Ibid.).

It is important to briefly state that there are a variety of perspectives related to transference and countertransference, including different definitions that correspond to the classical, Kleinian, and intersubjective models, among other major models. For purposes of this research study, this researcher will identify the classical perspective of transference and countertransference, which is a broader viewpoint, as well as a detailed description of these concepts from the classical perspective. Additionally, since the models of object relations and self psychology have been briefly presented as major psychoanalytic models, it is important to include their respective corresponding definitions of transference and countertransference. The object relational model has been selected as the most appropriate psychoanalytic framework within which to understand and treat the couple system and within which to frame this research study, and therefore a detailed description of transference and countertransference within this model is being included here.

It is noteworthy that, "In recent years countertransference has received increased attention in the psychoanalytic literature, perhaps as a result of greater focus on the analytic relationship." (Moore & Fine, 1990, p. 48).

Working with transference and countertransference is still a relatively "new" concept, especially within couples counselling. Transference and countertransference were originally identified by Freud (1910, 1915) in the process of his development of psychoanalytic theory. For many years, these concepts were considered by Freud to be a hindrance to therapy; later, he came to view transference as an essential component of the healing process. (Freud, 1915).

Although earlier theorists perceived countertransference to be an impediment to therapy, later theorists considered countertransference as a crucial component of the therapeutic process (Heimann, 1950; Little, 1951, 1957; Langs, 1976; Sandler, 1976; Feiner, 1979). The debate between opposing schools regarding countertransference continues. Many contemporary treatment models may acknowledge the importance of countertransference but do not view countertransference as having a central role in the treatment process, especially in couples treatment models. On the other hand, the concept of transference may not be acknowledged at all. Just as different schools of thought exist regarding transference and countertransference, some therapists choose to acknowledge and use these concepts while others do not or will not. Therapists' lack of use of these concepts or their misuse is often based on lack of awareness, not knowing how to use these concepts, or simply consciously or unconsciously avoiding them.

According to the classical perspective, the therapist's role is fundamentally one of objective observer. He/she remains outside of the couple system, making observations, interpretations, and analyses of the couple's dynamics as the couple engages in their own specific dyadic dance. During the counselling session the client couple experiences transferential feelings toward each other as well as to the therapist. The feelings that are being projected from one spouse/partner onto the other outside of the therapeutic setting are currently being replayed for the therapist with his/her guidance. The two partners are made aware of their faulty or dysfunctional behaviour or

communication patterns, and they are taught new and functional patterns that they are able to practise and integrate both within and outside of the therapeutic setting. In this manner the therapist is the expert observer who observes, interprets, and analyzes the dance but does not actively participate as a partner in it. According to the classical definition,

> Transference is the experience of feelings, drives, attitudes, fantasies and defenses toward a person in the present that do not befit that person but are a repetition of reactions originating in regard to significant persons of early childhood, unconsciously displaced unto figures in the present. (Greenson, as cited in Goldstein, 1995, p. 204).

The significant person who is the recipient of the transference is often the other partner within the couple system, and the couples counsellor within the therapeutic relationship.

From the classical perspective, there is a temporal consideration in that the client is able to make a distinction between the past and the present; displacement is the mechanism by which **the transferential process** is made. (Greenson, 1967). The client's perception is viewed as a distortion of reality; one that has been developed from their past. (Greenson, 1967; Stolorow, Brandchaft, & Atwood, 1987; Shapiro, 1995). Shapiro (1995) describes transference as "those feelings displaced from the past and projected in distorted fashion onto the analyst." (p. 30). The classical view prescribes an objective stance on the part of the therapist to allow for the observation, interpretation, and understanding of the patient's distortions to take place.

The classical definition of countertransference refers to the feelings, thoughts, and behaviour of the therapist, which are the result of his/her own "unresolved unconscious conflicts and deficits in his or her personality" (Hanna, 1997, p. 3) and therefore need to be harnessed in order to avoid exerting harmful impact upon the client and/or the therapeutic treatment. Freud's (1912) stance concerning countertransference was one that advised the analyst to be "opaque to the patient and like a mirror reflecting nothing but what was shown to him." (p. 118). As Hanna affirms, "There is an assumption underlying the classical position that, ideally, the psychoanalyst should remain perfectly objective when observing the patient's transference". (p. 3). Hanna points out that,

from the perspective of the classical position, "Countertransference reactions must be eliminated because they prevent the analyst from functioning as a scientist-observer. Analytic observations must be removed and separate enough from the field of observation so that they can be kept uncontaminated by the analyst's subjectivity." (Ibid). According to the classical position, the therapist who manages his/her countertransference reactions appropriately in order that they do not influence nor interfere with the therapeutic process, is able to make neutral observations and objective interpretations gleaned from the client's transference. As Maroda (1991) notes, "The notion of the 'incognito,' of the analyst hiding from the patient and therefore subtly encouraging the patient to hide from him, is at the heart of the countertransference debate." (p. 84). The ongoing debate centers around the need for a detached position on the part of the therapist, as opposed to a more active role where disclosure and use of the countertransference are considered to be beneficial to the therapeutic process.

> ...Tauber and Little believe that hiding does not further the uncovering of truth in the relationship, and therefore cannot further the analytic endeavour. On the other hand, those who think that the analyst should remain "incognito" believe that it is vital to focusing on the patient's – and not on the analyst's – truth. Therefore the key factor in taking a position on the appropriateness of disclosure of the countertransference seems to be whether you believe that it is possible to get to the heart of the patient's truth without also revealing some of the therapist's. (Maroda, 1991, p. 84).

As noted by Maroda (1991), concerning the classical position of transference,

> While many – Langs (1974), Greenson (1967), Gill (1982), Kohut (1971, 1977), Stolorow, Brandchaft and Atwood (1987) – favor acknowledging the patient's perceptions, most are quite conservative when it comes to actually expressing the countertransference; at best, they will only admit to gross errors when confronted by the patient. (Ibid).

Maroda contends that, "...their stance, while emphasizing empathy with the patient's feelings and representing a compassionate and enlightened view, still attempts to maintain the therapist's 'incognito'." (Ibid).

Hanna (1993) emphasizes that, "the classical view of transference and countertransference assumes that the therapist is the possessor of a more informed, knowable, objectively determined reality" (p. 37), and by working with the transference patients will be freed of their dysfunctional attitudes and feelings, and gradually accept the therapist's supposed healthy and neutral view of reality. (Goldberg, 1987, in Hanna). "The classical view tends to encourage clinicians to impose their view of reality onto the client" (Hanna, p. 31); this perspective emphasizes the therapist as the expert, objective observer required for effective intervention and treatment to take place.

The object relational view offers a broader definition of both transference and counter-transference. According to the object relations' perspective on transference, the patient's perceptions are not only considered to be distortions but also feelings, thoughts, and behaviours that are in reaction to something or someone in the present.

The early totalistic position of countertransference was developed by the Kleinian and British Independent object relations schools, which further expanded its definition to include "the totality of the therapist's personality and the reality aspects of the therapeutic situation" (Strupp, 1960, p. 28). The active role and subjective participation of both client and therapist are considered to be integral elements that are always operating in the therapeutic process, although "Early totalists still maintain a positivist view of countertransference, which must be contained so that the analyst does not contaminate the patient's transference distortion." (Hanna, 1997, p. 4). In contrast with the classical perspective of countertransference, "The earliest totalistic position acknowledged that the therapist's subjectivity is always active in the treatment process" (Ibid., p. 4), and, "This position emphasized the use of the therapist's total emotional reaction to the patient for diagnostic and treatment purposes" (Ibid) as opposed to something to be considered a hindrance to be appropriately controlled or avoided. There appears to be a compromise from the

early totalistic perspective where analysts were still viewed as "the arbiters of objective reality" (Ibid), and yet, "the analyst's subjectivity is legitimized because of its diagnostic and treatment potential". (Ibid). It is noteworthy that,

> Because British object relations analysts focus on the projection of internalized object relations onto the interpersonal field, the therapist's feelings and fantasies are regarded not solely as reflections of the therapist's dynamics, but as partly the result of the emotional impact of the patient on the therapist. (Ibid).

Both client and therapist actively influence each other's feelings, thoughts, and behaviours in the here-and-now of the therapeutic setting, and transference and countertransference are considered to be valuable elements through which a more comprehensive diagnosis and treatment can be attained.

The more fully developed two-person view of the object relational definition of transference (referred to as intersubjectivity in contemporary psychoanalytic theory is one that is interpersonal where both client and therapist are constantly impacting upon each other, and this mutual interaction is acknowledged in therapy; the transference that is operating is therefore co-created or co-constructed by client and therapist.

The later totalistic view of countertransference acknowledged the relationship between the projective identifications of clients and the therapist's containment functions (Bion, 1955); this relationship focuses on projective identifications as an interpersonal process. (Hanna, 1997). Kernberg (1965) distinguished between the classical perspective of countertransference and the totalistic view by emphasizing the interpersonal nature of projective identifications that occur between client and therapist. Additionally, Kernberg (1987) saw the value in projective identifications as a means with which the past and present were connected. According to Kernberg, "...repetitive cycles and the distortions that accompany them can be viewed as the nexus between past and present." (as cited in Siegel, 1992, p. 93).

Taking an ego psychological approach, Sandler (1976) redefined the concept of projective identification as role responsiveness. Sandler believed that role responsiveness is a universal characteristic of human interaction. In the treatment relationship, the patient and the therapist engage in enactments in which the patient represents himself/herself or a significant object and where the therapist takes on a complementary role. (Hanna, 1997). Sandler referred to this interpersonal dynamic as "role responsiveness", to describe the subjective experiences of both client and therapist that may come into play within the therapeutic process, and which requires the therapist's awareness in order for him/her to not be drawn into a passive compliance role that is activated by the client. According to this later totalistic perspective such transference/ countertransference enactments are inevitable but when brought into awareness after the fact, they may further the resolution of transference. "Later totalists acknowledge that therapists are participants in the process, not just scientifically detached observers." (Hanna, p. 5).

The concept of enactment is found within the context of the intersubjective view of transference and countertransference. Transference is considered to be co-created by both client and the therapist, and countertransference includes aspects of the therapist's own subjectivity in addition to that which is being impacted upon by the client. Enactments are carried out in the transference. From the intersubjective perspective, these enactments are considered as important elements found within the transference that need to be explored, analyzed, and interpreted by the therapist and then shared with the client to provide him/her with a new understanding. Patient-induced role enactments allow patients to experience trauma in the transference that promotes growth. This therapeutic experience takes the form of a compulsion that occurs as a repetition, and is carried out by the patient through role enactments. Hanna (1997) explains that, "patient-induced role enactments represent a compulsion to repeat developmentally archaic, traumatic object relations, or defensive role enactments to avoid activating traumatic states." (p. 5). Hanna emphasizes that, "This new relational experience is crucial to patients' efforts to re-

experience trauma in the transference in a manner that will facilitate mastery and growth" (p. 5). In the event that the therapist is unaware of these repetitions, "...patients' uses of their therapists as new objects may be severely compromised. The therapeutic relationship can then become stalemated, and in some cases, permanently derailed." (Ibid.).

The self psychological perspective defines transference and countertransference in terms of selfobject needs. According to Wolf (1988),

> *Selfobject transference* is the displacement onto the analyst of the analysand's need for the experience of a response selfobject matrix. It compromises derivatives from remobilized archaic selfobject needs of childhood as well as from current age- and phase-appropriate selfobject needs. (as cited in Bacal and Newman, 1990, p. 186).

Bacal and Newman emphasize that, "It should be noted that this is a *transference of need.*" (Ibid, p. 186). While the therapist may be perceived by the client as someone who can provide primitive or primary selfobject functions, nevertheless the therapist is also someone who is contributing to the transference that is taking place by accurately responding to the selfobject needs of the patient, inappropriately responding to the patient's selfobject needs, or avoiding responding to these needs altogether.

From a self psychological perspective, the transference is viewed as the therapist's failure to understand the client's selfobject need(s). The self psychological model privileges the original frustrated development need that is being activated in the present relationship. A counter-transference response may reflect a failure to empathetically understand and respond to a selfobject need.

The totalistic and intersubjective positions regarding countertransference, according to Hanna, emphasize the therapist's role as more of a subjective participant whose feelings, attitude, and behaviours are an intrinsic part of the therapeutic process. Just as there are different academic positions or schools of thought concerning the classification of the concepts of transference and countertransference, the choice of position on the part of the therapist varies and the therapist's

position will determine the extent to which he/she is an active participant or passive observer in the therapeutic process. Assuming the psychoanalytic view that transference is a significant feature of all human interaction, it could be argued that the therapist who is not consciously aware of the position that he/she is taking and cannot or does not therapeutically manage these phenomena appropriately, is failing to use a significant vehicle for furthering his or her therapeutic objectives. It is also possible that because of a failure to recognize transference and countertransference enactments in the treatment relationship, the treatment can cause harm to the client/client couple. (Winnicott, 1949; Epstein, 1979; Spotnitz, 1976; 1979; Maroda, 1991).

Section 2.8 The Role of Transference and Countertransference in Couples Treatment

According to Molnos (1995), "Today it is a fundamental tenet of all psychoanalytically based psychotherapies that internal problems originate in relationships. They re-emerge in relationships. They can also be healed in relationships." (p. 91). These healing relationships include the dyadic one shared by partners, and the therapeutic triadic one that the couple shares with the therapist. In describing couple therapy, Lachkar (1992) states that, "Couple therapy is a deep emotional experience of intense communication and feelings that occurs among three persons." (p. 100).

The use of the psychoanalytic model and the concepts of transference and countertransference found within it, in order to attain insight, understanding, and treatment for the self and the self-in-relation-to-other, is clear. Since most intrapsychic and interpsychic conflicts in the present are attempts to resolve these types of conflicts and issues that are triggered in the here-and-now but often stem from early past significant relationships, the therapist needs to work within the psychoanalytic framework. While the mates attempt to resolve their old conflicts from the past unconsciously through their present relationship, "It is also through the therapeutic relationship that the patient reaches a deeper understanding of the psychic mechanisms underlying his troubles." (Ibid.).

Maroda (1991) emphasizes the need for awareness on the part of the therapist and the patient

to the presence of repetitions, in order for the therapist to interpret them and provide meaning to them. According to Maroda,

> Rules of technique say that interpretations must be made at this point, that the patient must be aware of what he is trying to do. The belief is that armed with this insight, he will be less inclined to persist in pursuing these repetitions. (p. 23).

Maroda maintains that, "It would be foolish not to acknowledge the element of truth in this. Obviously there is a reason why we all seem to expertly arrange for the same situations to recur in our lives over and over again..." (Ibid).

Kershaw (1992) highlights the importance of the assessment of couple dynamics and the need for awareness on the part of both therapist and couple, of the intrapsychic and interpsychic dynamics that impact upon interactional events. Lankton and Lankton (1986) as well as Kershaw maintain that, as therapists begin to comprehend the current developmental stage of each dyadic mate as well as that of the partners as a couple, the treatment interventions will naturally ensue as a direct consequence of their understanding.

Fairbairn (1952) developed his theory to extend beyond intrapsychic forces to include the child's need for a relationship with the caregiver; the interpersonal relationship became the central focus with transferences from this significant past relationship arising as distortions in the present. It is within the present intimate love relationship that conflictual issues from the earlier significant relationship are replayed on both a conscious and unconscious level. "Dicks (1967) was the first to note that in marriage one's self was the other's object, and thus projective identification was a mutual process." (as cited in J. S. Scharff, 1991, p. 18). Dicks (1967) observed that marital compatibility was based both upon a conscious and an unconscious "fit". Shapiro and Zinner (1972) determined that every current relationship within a family is characterized by a two-way transference distortion. (as cited in Scharff & Scharff , 1991). Shapiro and Zinner (1972) also determined that within each family, there exists a specific object relations set that exists on an unconscious level and transforms the family into a "single psychic

entity". This theory is extended to the couple relationship where partners develop a shared interpsychic mode of relating and communicating, within their own internal world and how they present to the external world.

As stated earlier, Hendrix's development of imago theory is based upon the premise that individuals choose mates who resemble their earliest caretaker and who remind them of the unconscious and conscious experience of their initial caregiving relationship. Herein lies the explanation for the unexpected frustration and conflict that surfaces within the intimate relationship. Every individual holds "the ideal of the unconscious search for a person who matches our imago." (Hendrix, 1988, pp. 45-46). The "imago" is the idealized partner, based on unconscious needs and desires, of which partners are not consciously aware. By understanding that we have unconsciously chosen partners who remind us of our earliest caregivers and the unresolved issues from that relationship, and, "by understanding how past unresolved feelings periodically surface, it is easy to understand why we can become so easily hurt by our partners." (Gray, 1992, p. 275). As Framo maintains, "...family of origin issues are fundamental to people's intimate or relationship problems." (as cited in Chasin, Grunebaum, & Herzig, 1990, p. 49), and "...hidden transgenerational forces exercise a critical influence on present intimate relationships." (Ibid.).

Transference and countertransference are psychoanalytic concepts found within the object relational model, which may be viewed and used as indispensable therapeutic tools in the intricate peeling, revealing, and healing process of couples treatment. These tools have the capacity to not only peel back the multiple layers of unconscious functioning of the individual partners to reveal the roots of each partner's object needs and their shared "objects set" as a couple, but when applied appropriately, these tools help partners to recover and heal.

It is important to point out that much of the general discussion of the various psychoanalytic views of transference and countertransference also applies to couples work; for example, the transference that occurs from individual client to therapist also takes place in couples counselling,

as does the countertransference that belongs to the therapist and is directed at the client. It must be noted, however, that there are also distinct differences; for example, the transference that is present in couples therapy is occurring as different types and in different ways. As will be discussed within this section, there is the transference that occurs between partners within the couple system, the transference that takes place from each individual partner and is directed to the therapist, and there is a shared transference that is directed from the couple to the therapist. The role of transference in couples treatment is also one that is distinct from individual therapy. As well, the countertransference that is present in couples therapy is one that the therapist may experience both in reaction to the partners as a couple system in addition to each individual mate. As in the case of transference, the role of countertransference in couples therapy takes on a variety of characteristics distinct to the treatment of couples, and this translates into additional considerations for the therapist who works with couples.

In their clinical work, Scharff and Scharff (1987) examine both the couple's transference to the therapist and how the therapist's countertransference can be used effectively in the treatment of the couple. (as cited in Scharff & Scharff, 1991). Scharff and Scharff refer to the "contextual transference" in which the therapist acts as the external object providing a secure, holding environment in which intimate interpersonal relating can occur. The "focused transference" occurs when the therapist is experienced as the external object for unconscious, mutual projection of internal object relations. (Scharff, J. S., 1991). In their clinical treatment of couples and in their writing, the Scharffs demonstrate how use of both transference and countertransference can reveal a deeper understanding of the couple's unconscious object relations, and also function as therapeutic tools to guide both couple and therapist to a healthier mode of relating.

The projection of object needs takes intrapsychic conflict into the interpsychic arena shared by both partners within their dyadic relationship, and the concepts of transference and countertransference can be used to reveal these issues and their sources of conflict. While there are several purposes of projective identification in the couple relationship, and the tools of

transference and countertransference may be used to uncover and identify their existence and purpose in the dyadic relationship, one of the most critical goals is "the pathway for psychological change" (Ogden, 1986) that may be accomplished through the projection-recipient relationship within marriage with one's spouse or within therapy in the patient-therapist relationship.

The concept of projective identification emanates from the initial mother-infant relationship, originating in the past. (Ogden, 1982, 1986, as cited in Scharff & Scharff). Although Ogden, known to be a therapist working with individuals, focused on the nature of projective identification as an interpersonal interaction, he mainly observed the impact of the therapeutic relationship between therapist and patient, in terms of how the two respond to each other's projective fantasies and psychological processing. It was Dicks (1967) who focused on marital studies. However, interestingly, Ogden's and Dicks' emphasis on the influence of the primary caregiver relationship is the same. The concept of projective identification can be used to understand the dynamics between therapist and client, as well as the couple dynamics between partners, and the tools of transference and countertransference may be used to uncover, discover, and explore the interactional dynamics of mates. The therapeutic relationship and its dynamics frequently mirror the relationship shared by the couple and their dyadic dynamics.

Zinner and Shapiro (1972) applied their perspective of the intrapsychic process of projective identification to interpersonal situations in the life of a family system. Zinner (1976) later built on Dicks' (1967) research and also contributed to the area of marital therapy. Zinner emphasized that "projective identification is an *unconscious* process with defensive and restorative functions" (Scharff & Scharff, p. 52), and he maintained that it is "an unconscious intrapsychic process through which conflict can be contained inside the self or projected out into a relationship." (Ibid). This theory has major implications for the couple system. Both Dicks and Zinner observed that, "this happens in marriage and that the process not only alters how the self perceives the object but actually evokes a collusive response in the object." (Ibid).

Zinner (1976) refers to "the process of projective identification as a process that can be both healthy and unhealthy" (Zinner as cited in Scharff & Scharff, p. 53), and maintains that, "Depending on the extent of the use of projective identification, the nature of a marriage relationship may fall anywhere on a continuum from normally empathic to frankly delusional." (Ibid). It is important to emphasize that when a mate uses projective identification not as a way of externalizing conflict but rather as a method for the two partners to share experiences and thus become closer, the marital or dyadic relationship is more characteristic of a healthy one. (Zinner in Scharff & Scharff). Turner and Shapiro (1972) described "projective identification" in marriage as the situation in which the subject views the object as if the object contains significant parts of the subject's personality, and Ogden tied "identification" to "oneness", implying that the purpose of identification is the individual's desire to attain a sense of "oneness" with the mate

The model of object relations has been selected as the most useful framework in which this research study has investigated the treatment of couples by social work practitioners and other therapists. The concepts of transference and countertransference, as uniquely defined and applied for understanding and treatment within this specific model, are highlighted as the useful therapeutic tools with which therapists can facilitate their work with couples. Clearly, these concepts can be viewed and used as efficacious tools within the therapeutic setting to develop insight, increase understanding, and to develop healthier modes of relating and communicating, and yet it is uncertain how many therapists use or even consider these concepts in their clinical practice.

Molnos (1995) maintains that, "the central overriding, and ultimate aim of a complete psychodynamic therapy is both to find one's own unique individuality and to be able to hold on to it while relating to others in a mutually constructive, life-enhancing way." (pp. 91 - 92). This objective is certainly the goal of couples counselling, where the focus is two-fold and centers on the healthier functioning of each individual partner intrapsychically and on the partners' dyadic dynamics as they relate interpsychically as a couple system.

As De Angelis (1992) maintains, "Locating the persistent, negative patterns in your relationships is the first step toward eliminating those patterns." (p. 57). A number of authors have stated that a successful psychoanalytic therapy provides "a corrective emotional experience" (Alexander & French, 1946, as cited in Kahn, 1997, p. 99). The corrective emotional experience may be attained by the therapist facilitating the patient's revisiting of the past, and then carefully and competently applying an awareness of the natural phenomena of transference and countertransference as therapeutic tools in collaboration with the client/client couple. The understanding derived from the use of these phenomena is cautiously and conscientiously deconstructed in order to later gradually reconstruct a new relational mode for the couple in the present. It is during this deconstructing and reconstructing process that the old, maladaptive patterns originating in the past may be reenacted and thus revealed, and the partners are given a valuable opportunity within the therapeutic setting that they would not be able to experience anywhere else; that of unconsciously revisiting their past, reenacting the old, dysfunctional patterns that were created in infancy and further developed in childhood, and then consciously being able to learn, enact, and integrate newer, healthier forms of functioning, in terms of the self and the self-in-relation-to other. The "self" is that of each partner and the "other" is the mate within the intimate relationship with whom he/she interacts, cognitively and affectively, physically and emotionally, functionally and dysfunctionally, consciously and unconsciously.

It is important for the therapist who treats couples to remember that transference reactions occur between client/client couple and therapist, as well as between partners. While it is essential to note that, "We are involved in transference reactions not just with analysts but with...spouses" (Alford, 1991, p. 25), it is also critical to note that the transferential relationship that develops between patient and therapist mirrors the dyadic relationship of the romantic partners and the initial caregiver relationship experienced by each partner. While "current marital and parental difficulties are largely reparative efforts to correct, master, defend against, live through, or cancel old conflicts from the original family" (Chasin, Grunebaum, & Herzig, 1990, p. 40), the roots of

this intrapsychic conflict that manifests itself within the interpsychic relations of mates remains hidden until revealed to both therapist and client/client couple. It is only when an awareness and an acknowledgment of these conflicts and the origins of these old anxieties and longings can be discovered and identified, that corrective functioning and healing can begin. The concepts and experience of transference and countertransference can be effectively used to discover the critical elements from the past that were fulfilling or missing, and that are presently being sought within the present intimate relationship. Chasin et al. maintain that, "These conflicts and **transference** distortions from the past are lived anachronistically through the spouse and children...People try to handle their old anxieties through a current relationship; they attempt to make an interpersonal resolution of intrapsychic conflict." (Ibid.)

Transference and countertransference are invaluable phenomena that may be viewed and applied as instruments, effective in the therapeutic technique of psychoanalysis, because they can help the couples therapist and the individual partners themselves to trace back and explore the roots of issues related to "connection", "attachment", and "identity". Therapists are able to gain fresh insight into the unconscious needs and desires of the partners individually, share this insight with them, and then help the partners to co-construct a new understanding of themselves, their own functioning, and that of the other partner. This new understanding and the new experience that it facilitates can help partners learn how to relate and communicate their needs, desires, and feelings to each other in a mutually healthier and more fulfilling way.

This researcher views transference and countertransference as the invaluable data that are keys to unlock the door to observe, analyze, interpret, and help the couple to "work through" and heal from the wounds that continue to interfere with their current relationship. The psychoanalytic therapeutic process will guide the couple to healthier and happier patterns of "dyadic dancing" or functioning together. Additionally, these concepts can be used as therapeutic tools to facilitate healthy resolution of conflictual issues through a "working through" process, and a replacement of more functional modes of relating through a corrective emotional technique.

Most of the literature published in the area of couples counselling does not adopt the psychoanalytic perspective as a model of understanding and intervention; furthermore, the research studies that have been done to demonstrate the effectiveness of couples counselling within the psychoanalytic paradigm do not address nor investigate transference and countertransference as potentially integral components. The few research studies that have examined transference and countertransference are in the context of treatment of individuals, not couples. It is also significant to note that most research studies that focus on the application of the psychoanalytic paradigm (which may be classified as Insight-Oriented Therapy or Emotionally Focused Therapy) to couples therapy, are outcome studies. The few studies that examine process, do not make any reference to transference and countertransference as therapeutic tools that may be used effectively in working with couples.

Section 2.9: <u>Relevant Research Studies:</u>

In this section, empirical support for the psychoanalytic model and the associated concepts of transference and countertransference is briefly reviewed. The reader will find a summary of two research studies that demonstrate empirical support for the effectiveness of psychoanalytically informed models of marital therapy (Snyder & Wills, 1989; Johnson & Greenberg, 1985b). This is followed by a review of two studies that have found strong empirical support for the concept of transference, by demonstrating strong parallels between themes in patients' relationships with significant others and themes in the relationship that the patient develops with his or her therapist (Fried, Crits-Christoph, & Luborsky, 1992; Connolly et al., 1996). Next, studies that have demonstrated a significant relationship between transference interpretations and positive therapeutic outcome are reviewed (Sifneos, 1966, 1967, 1972; Malan, 1976). The section concludes with a review of two studies that have investigated therapists' countertransference (Sehl, 1998; Mendelsohn, Bucci, & Chouhy, 1992).

Research findings have demonstrated that the qualities of accessibility and responsiveness of the marital therapist are "the building blocks" of a secure, intimate bond (Johnson, 1986; Sroufe, 1979), and that it is within this secure and intimate bond that marital partners are able to have their attachment needs fulfilled and also accept the differences that realistically exist between them. The research conducted by Snyder and Wills (1989) on IOMT (Insight-Oriented Marital Therapy) intervention, promoted the important qualities of accessibility and responsiveness by an "uncovering and explicating" of each mate's experience of themselves, the other, and their overall dyadic relationship.

Using a controlled outcome study, these researchers focused on a comparison of the effects of behavioural marital therapy (BMT) and insight-oriented marital therapy (IOMT) on "both interspousal and intrapersonal functioning". While the findings demonstrated both "a significance and general equivalence of behavioural and insight-oriented therapies in producing positive changes in individual and relationship functioning" (p. 39) from the intake stage through to the termination stage of therapy, and also demonstrated that these positive changes were "substantially maintained at the 6-month follow-up" (p. 39), nevertheless there were significant differences that confirmed that insight-oriented therapy was the superior model in terms of reaching and promoting the critical elements of accessibility and responsiveness.

Before treatment, couples were asked to rank order what they considered to be the five most difficult problems impacting upon their marriage. Among the commonly identified four most difficult problems were "a lack of meaningful communication (34%), an inability to resolve differences (34%), a conflict or disappointment in the sexual relationship (27%), and feelings of emotional alienation from the spouse (25%)." (Snyder & Wills, 1989, p. 40). The Global Distress scale (GDS) of the Marital Satisfaction Inventory (MSI, Snyder, 1981) was employed to assess a wide range of interspousal and intrapersonal functioning, and to accurately identify distressed and non-distressed couples. Additional inventories and scales were employed to determine the extent to which individual partners were motivated to change, the degree to which

each partner wanted the other to change, and then, finally, to assess any changes that had occurred in individual functioning as a result of the marital therapy. At intake, termination and 6-month follow-up, individual partners' interactions on both a verbal and non-verbal level, were coded according to Gottman's (1979) Couples Interaction Scoring System (CISS) to indicate both positive and negative communication, behaviour and affect of partners. (as cited in Snyder & Wills, p. 41).

In the BMT group, interventions were:

> ...based on a behavior-exchange and skills-training model summarized by Jacobson and Margolin (1979) that comprise four distinct components -communication skills, problem-solving skills, relationship enhancement and contingency contracting - all of which emphasized immediate changes in the couple's interactions and the development of relationship competency. (Ibid.).

This model focused on, "shaping procedures and homework assignments, behavioural instruction, modeling, rehearsal, and feedback" (Ibid.) to facilitate partners' development of certain relationship skills in order for them to integrate effective marital interaction patterns. However, in this BMT model, "the dynamic exploration of feelings, the analysis of motivation, and the attribution of responsibility to the other persons or events were all minimized." (Ibid.) It is significant to note that, "In contrast, the IOMT emphasized the resolution of conflictual emotional processes that exist either within one or both spouses separately, between spouses interactively, or within the broader family system." (Ibid.). This model aimed to "integrate individual, couple, and family functioning by addressing developmental issues, collusive interactions, incongruent contractual expectations, irrational role assignments, and maladaptive relationship rules." (Ibid.). The therapists employing the IOMT model engaged in:

> ...probes, clarification, and interpretation in uncovering and explicating those feelings, beliefs and expectations that spouses had toward themselves, their partners, and their marriage, that were either totally or partially beyond awareness, so that these could be

restructured or renegotiated at a conscious level. The emphasis was on the interpretation of underlying dynamics that contributed to the current, observable marital difficulties. (Ibid.).

IOMT couples demonstrated "significant gains in nonverbal positiveness from intake to termination." (Ibid., p. 42). Additionally, "findings indicated that IOMT and BMT resulted in statistically significant improvement for 73% and 62% of couples assigned to these two conditions, respectively, in contrast to a 15% improvement rate for TOD (treatment-on-demand waiting-list control group) couples." (Ibid.). It is noteworthy that, "By comparison, deterioration was observed in none of the IOMT couples, in 1 BMT couple, and in 2 TOD couples." (Ibid, p. 43). Snyder and Wills had found deterioration rates for the BMT couples of 3.4% pretreatment to posttreatment in comparison to the IOMT couples who had no deterioration, and 8.3% from posttreatment to follow-up. (p. 44). It is important to note that, "...these researchers did find differential effects in favor of the insight-oriented interventions at 4-year follow-up (Snyder, Wills, & Grady-Fletcher, as cited in Johnson & Greenberg, 1991, p. 407). Studies done by these researchers demonstrated that there were, "...deterioration rates for BMT couples...(from 35% to 46% comparing 4-year follow-up to intake, termination, or 6-month follow-up status"), and these researchers later stated that findings of this study, "...are consistent with the meager literature regarding long-term efficacy of marital therapy in general." (Snyder & Wills, as cited in Snyder & Wills, 1991, p. 432). As well, Snyder and Wills (1991) report that when these couples were followed up 4 years after the therapy terminated, a significantly higher percentage of BMT couples (38%) had experienced divorce than had the couples in the IOMT condition (3%). (p. 428). This study by Snyder and Wills has therefore demonstrated empirically that a psychodynamically informed therapy is not only effective, but, for some couples, may be more effective than a behavioural approach.

Johnson and Greenberg (1991) maintain that this process of uncovering and explicating, promoted by Snyder and Wills (1989) and also central to the EFT (Emotionally Focused Therapy) model, would strengthen the couple bond shared by partners. In EFT, there is a focus

on "feeling" questions that initiate "the beginning of an intrapsychic exploration and reprocessing of emotional responses underlying the positions that each partner took in the relationship." (Ibid., p. 411). Both therapist objectives and therapist interventions are critical in that they "stimulate interaction", and within the framework of the EFT model, the objective is "not to label an emotion but to access and heighten the full experience of the emotional response so that it may be reprocessed and new aspects of self integrated into the sense of self and into the couple's interaction patterns." (Ibid.)

Numerous research studies have also demonstrated the significance of the therapeutic alliance and the interaction effects of the therapeutic relationship. Johnson and Greenberg (1989) demonstrated the significance of the therapeutic alliance as a key component to effective change events taking place in marital therapy. In Johnson and Greenberg's study that focused on the Emotionally Focused Marital Therapy (EFT) model, these researchers determined that a positive and strong therapeutic alliance between therapist and each spouse as well as with the entire couple system is "an essential prerequisite of key change events in EFT".

Greenberg and Johnson (1988), and their colleagues engaged in research studies to investigate the effectiveness of emotionally focused therapy (EFT) in working with couples, and concluded that this type of therapy is effective. Their research also focused on the process of change in EFT and demonstrated how client performance was rated in terms of the extent of experiencing, and the quality of interpersonal interactions. (1986, 1988). The methodology of this study involved the selection of couples "...from the subject pool of an EFT efficacy study." (Johnson & Greenberg, 1985a, as cited in Johnson & Greenberg, 1988, p. 177), and the mean duration of time that couples were together in partnership was 8 years. There were twenty-nine couples who initially received EFT and a control group who was given EFT treatment later. "EFT is an integration of the experiential approach to psychotherapy, which emphasizes the role of affect and intrapsychic experience in change" (Greenberg & Safran, 1987; Perls, Hefferline, & Goodman, 1951 as cited in Johnson & Greenberg, 1988, p. 176). According to Greenberg and

Johnson's research (1988), "The essence of the change process in this approach is...considered to be the accessing of emotional experiences underlying problematic and rigid interactional positions, and the resynthesizing of such experiences to create new interactions." (p. 176). Three couples were later chosen as "low-change couples" for whom EFT therapy demonstrated the smallest amount of change as well as three couples considered to be "high- change couples" since EFT therapy had created the greatest amount of positive change for them. All of these couples were given eight sessions of therapy by practitioners who had been trained in EFT therapy. The post-treatment scores on two scoring scales, including a scoring scale for intimacy, rose higher for the high-change couples after the EFT sessions, than for the low-change couples. "It was hypothesized that couples who showed dramatic improvement in therapy would exhibit, in 'best' therapy sessions, high levels of experiencing, more autonomous and affiliative responses, particularly by blaming spouses, and more instances of 'softening' of interactional stances." (p. 177). According to Greenberg and Johnson, "This kind of research, relating client in therapy process to successful outcome, is an attempt to begin to describe and explain change processes and to begin to construct a model of change in marital therapy." (p. 181). These researchers conclude that, "The empirical demonstration of the validity of clinical intuition regarding potential change events is essential." (Ibid.).

Greenberg and Johnson (1988) maintain that, "Such models of change are vital if the marital therapy field is to continue to develop and to begin to differentiate which strategies and interventions are most effective with which clients at particular times in therapy." (Ibid.). These researchers point out that, "...strategies and interventions are becoming less and less differentiated across different models of therapy, with analytic and behavioral therapists using the same interventions for different purposes (Johnson & Greenberg, 1987) and obtaining similar global treatment effects (Johnson & Greenberg, 1985)..." (as cited in Johnson & Greenberg, 1988). These researchers emphasize the importance of understanding "the essential client operations involved in relationship redefinition" (p. 182), in order for a therapist to then be able to "...choose

specific techniques to facilitate specific processes at specific times." (Ibid.) In concluding their discussion of the findings of their study, the researchers state that, "A first step in this direction is, then, to describe the client change process hypothesized to occur in various models of therapy and to empirically test if, in fact, such processes occur and are linked to specific outcome." (Ibid.) It is important to note that, "...the results suggest that a high level of experiencing involving the exploration and reprocessing of emotional experience, the facilitation of disclosing and affirming interactions and the creation of a 'softening' event are important elements in successful experiential marital therapy." (Ibid.) These findings have significant implications for clinical practice with the focus on affective processes, as well as for ongoing research in this area.

As can be seen from this review, while the research studies that have been conducted report significant findings in terms of the effectiveness of couples counselling, using such psychodynamic approaches as emotionally focused marital therapy and insight-oriented marital therapy, they do not specifically examine or mention transference and countertransference. It is significant to note that, theoretically, awareness of and analysis of transference and countertransference lead to insight and understanding. This researcher would like to emphasize that her understanding of the potency of transference and countertransference as therapeutic tools is in their effectiveness within the therapeutic process to create and maintain these essential elements (i.e. understanding and insight) both within the therapeutic triadic relationship and within the couple's dyadic relationship, to bring the couple to healthier and happier functioning on a mutually satisfying level.

Henry, Strupp, Schacht, and Gaston (1994) have examined the various psychodynamic approaches, and analyzed the use of transference, specifically transference interpretations, in psychodynamic therapy. These authors discuss the use of transference interpretations as "the hallmark of psychoanalytically oriented technique in psychotherapy" (Ibid., p. 469), and remind that "the widely held orthodox view posits that the 'ultimate instrument' of therapeutic change is

the 'mutative interpretation' of the fully developed transference neurosis. (Strachey, 1934)." (Ibid.). Their work did not involve couples.

It is relevant to note that some authors, clinicians and researchers have argued that "transference interpretations should be avoided altogether" (p. 469); others continue to see them as "indispensable". (p. 469). It is also important to note that, while some researchers contend that transference is not explicitly connected with the past, nevertheless they maintain that, "transference and its interpretations are a crucial element in a treatment relationship" (Binstock, Semrad, & Bloom, 1967 as cited in Malan, 1976c, p. 39). Other researchers assert that the connection with the past is a critical component of therapy, and transference is key to revealing and explicating the importance of this connection to a significant person from a relationship in the past. (Menninger, 1958; Mann, 1969). Henry et al. emphasize that, "the question of the optimal frequency of transference interpretations (and indeed, whether to employ them at all) has become a more compelling question with the advent of short-term therapists." (Ibid.). Even Gill (1982), a compelling advocate of transference interpretations, cautions against their "overuse".

Although several studies (e.g. Davanloo, 1978; Malan, 1976a, 1976b; Mann, 1973; Sifneos, 1972) have found a strong relationship between the frequency of transference interpretations and positive outcomes, only two (those by Sifneos and Malan) will be reviewed here. Once again, these are outcome studies rather than process-oriented ones, and they do not examine the use of transference and countertransference in working with couples.

The focus of Sifneos' work (Sifneos, 1966, 1967, 1972, as cited in Malan, 1976a) was on "The importance of early and repeated interpretations of resistance, ambivalence, and negative transference in order to maintain the therapeutic alliance" (as cited in Malan) as well as "repeatedly using examples from the transference; and making the patient aware of repetitions in past patterns in the transference relationship" (Ibid.). The premise of Sifneos' work centered on how an interpretation of the negative transference by the therapist as well as an awareness on the part of both therapist and patient of repeated patterns in the transference relationship, were

significant components of the therapeutic change process as well as critical contributors to positive outcome. Sifneos concluded that, in terms of outcome, psychotherapeutic intervention was effective, and even after treatment ended, the results were evident in "the substitution of a new defense for an old one" (1967), and that "dynamic changes have taken place" (1966) (as cited in Malan)

Malan's studies (1963) had, as their focus, "the relation between outcome on the one hand and various aspects of *transference interpretation* on the other." (Malan, 1976a)

Here it emerged that those therapies tended to be successful in which:

1. Transference arose *early;*
2. The *negative* transference was thoroughly interpreted;
3. The link was made between the transference and the relation to *parents* (the transference/parent or T/P link); and
4. The patient was able to work through grief and anger about *termination.* (Ibid., p. 52)

Malan states that, "The most striking of these correlations was with the transference/parent link" (Ibid., p. 52). In addition to including the clinical judgements of therapists, Malan also employed a quantitative method using a content analysis of the therapy sessions where he made a note of each interpretation, determined whether it made the T/P link, then added the number of interpretations that made the T/P link and divided them by the total number of interpretations that had been recorded for that particular therapy. Malan termed this final numerical value the "transference/parent ratio". He states, "When these figures were compared with the scores for outcome over the whole series, the resulting correlation was positive and significant." (Ibid.) Malan's first series of studies enabled him to conclude that, "there thus seemed overwhelming evidence from the first series against the conservative view that in brief therapy transference interpretations are harmful, and strongly suggestive evidence that on the contrary they may constitute a major factor leading to therapeutic effects." (Ibid.).

Malan followed up with an additional series to further study and confirm the relationship between transference and outcome. In his work, Malan considered transference to be a critical component to successful technique in therapy.

> In the second series, "*the transference/parent link*" was confirmed in a most striking manner: In a very detailed content analysis, the correlations between outcome and a large number of different kinds of interpretation were studied, and the transference/parent link not only headed the rank order by a large margin but gave the only correlation that was significant. (Ibid., p. 53).

Malan emphasizes the significance of the *"full-scale psychodynamic history"* (Ibid., p. 250) and asserts that, "The psychodynamic history must include a thorough history of the patient's relationships, with particular reference to any clear-cut patterns that emerge." (Ibid.). Malan explains that, "This can lead to an assessment of the depth of disturbance in relationships, and also to the possibility of forecasting the type of transference likely to develop." (Ibid.). While researchers like Malan emphasize the critical necessity of exploring past significant relationships as well as current ones to explicate both past and present functioning of the individual, it is transference interpretations that reveal these influential factors. "Transference is interpreted within the framework of the focused central conflict...The interpretation includes the past, the present, and the therapist" (Mann, 1969, as cited in Malan, 1976a)

Moving now to more recent studies of transference and countertransference, two studies have demonstrated that definite similarities can be found between themes in patients' relationships with significant others and themes identified in the relationship that the patient develops with his or her therapist. These studies provide strong empirical support for the ubiquitous nature of transference.

Fried et al. (1992) engaged in what they refer to as "The First Empirical Demonstration of Transference in Psychotherapy" where they examined the similarity between patients' relationships with significant others in their life and their therapeutic relationship with the

therapist. The objective of their research was the presentation of the "generalized transference reaction" that Greenson had described (Greenson [1967] as cited in Fried et al., 1992).

Fried et al. (1992) maintain that,

> Although the transference observation has been relied on clinically ever since Freud's first description, there has been no systematic study of the degree of parallel to be found in psychotherapy sessions between the main relationship pattern and the relationship with the therapist. (p. 326).

The study by Fried et al. (1992) was specifically designed to illustrate the association that exists between patients' relationships with significant others from the past and their present relationship with their therapist. These researchers examined patterns identified from psychotherapy session transcripts and they used the Core Conflictual Relationship Theme (CCRT) method developed by Luborsky et al. (1980), to identify these patterns. This method is "a system for coding the content of the general relationship pattern, including the patient's experiences with the therapist." (Ibid.). They had a sample of 35 subjects identified as new patients who were requesting treatment as outpatients. Two clinicians identified the patients according to the DSM-III diagnosis manual and "the predominating diagnoses were dysthymic disorder, generalized anxiety disorder, and variety of personality disorders." (Ibid.). The 35 patients were asked to tell "narratives" about their present therapist during therapy sessions, which were transcribed. The mean length of treatment was identified as 56 weeks and sessions were held once a week.

It is significant to note that Freud had identified many different facets of transference which are categorized or classified as "observations" in the CCRT table. "These observations deal with the origin, the functions, and the stimuli that activate the transference." (Ibid.). As well, "They include the observations that it involves a central relationship pattern, that it originates with the early parental figure, and that it comes to involve the therapist." (Ibid.). Fried et al. (1992) found that there was a good correspondence of 17 out of 22 of Freud's observations with CCRT

evidence. One of the observations confirmed that there is a transference pattern that exists both within and outside of the psychotherapeutic context.

The analysis was focused on the patients' relationship episodes that involved "a significant person in the patient's life, for example, a parent, sibling, friend, spouse, boss, or therapist." (Fried et al., 1992, p. 327). The primary finding of this empirical study was that "patients have a relatively unique and pervasive relationship pattern, with a demonstrable parallel between the experience with the therapist and the experience with others." (Ibid., p. 328). The researchers maintain that, "This is in accordance with Freud's 'stereotype plate' formed early in the patient's life and including the therapist and those outside the treatment." (in Fried at al.).

The particular study previously referred to, "offers the first empirical evidence in support of the original definition of transference as a relationship template replicated across various people in a patient's life." (Ibid., p. 329). As well, this study "demonstrated that there is a significant similarity between the patient's experiences with a therapist and with others." (Ibid.). The authors of this study maintain that,

> Studies using the CCRT method have shown considerable fit with several of Freud's key observations about transference: wishes conflict with responses from self and others; the relationship pattern originates in early parental relationships; interpretation changes the expression of the pattern; the pattern is expressed in multiple ways, *e.g.,* in dreams and narratives.
>
> (Crits-Cristoph et al., 1988a, 1988b; van Ravenswaay et al., 1983, as cited in Fried et al., 1992, p. 329).

The findings confirmed, "a consistency between the way the therapist is experienced and the way others are generally experienced; this provides new empirical support for this central aspect of transference" (Fried et al., p. 330).

Another recent research study that was done to examine the relationship between transference patterns in the interpersonal experiences from patients' pasts and those found within the therapeutic relationship with the therapist in psychotherapy (Connolly, Crits-Christoph, Barber,

& Luborsky, 1996) concluded that *there was a strong correlation present.* The researchers maintain that, "Theories of dynamic psychotherapy are based on the premise that patients form maladaptive relationship patterns in early relationships that result in problematic adult interpersonal relationships." (Connolly, Crits-Christoph, Barber, & Luborsky, 2000, p. 356). Connolly et al. (1996) demonstrated that the transference patterns originating in significant relationships from patients' pasts were highly similar to those found in the therapeutic relationship with their therapist. As with the study of Fried et al. (1992), these findings were based upon narratives that the patients were requested to write, concerning their therapist.

The study included:

> ...an exploratory analysis of the similarity of patients' pre-treatment interpersonal themes with the theme evident in therapist narratives across both early and late psychotherapy sessions. The objective of treatment was to facilitate patients' understanding of their maladaptive relationship patterns within the contextual framework of a supportive therapeutic relationship and atmosphere. (Connolly et al., 2000, p. 359).

The main techniques involved were "...supportive techniques to bolster the therapeutic alliance and interpretive techniques aimed at self-understanding of the impairing relationship conflicts" (Connolly et al., 2000, p. 359). It is interesting to note that, "A descriptive analysis of three early sessions for these patients revealed that sessions contained an average of five interpretations per session, which most often focuses on patients' relationships with parents and significant others in the present time frame." (Connolly et al., 1998, as cited in Connolly et al., 2000, p. 359). Connolly et al. also noted that,

> Although transference of interpersonal themes to the therapist is included as an important element in the SE model, less than 10% of therapist interpretations dealt directly with the enactment of maladaptive interpersonal themes in the relationship with the therapist. (p. 359).

These researchers determined that, "In SE psychotherapy, transference of interpersonal themes forms the basis for the therapist's understanding of the patient's symptoms...In addition, the therapist uses his/her own experience of the therapeutic relationship to inform the dynamic formulation." (Ibid., p. 368).

Limitations of this study included that the measure of transference was based only upon the personal narratives of patients and any "subtler aspects of transference patterns were not assessed using the current methods." (Ibid, p. 369). The researchers also felt that the small degree of transference could have been related to the fact that the model considered was "time-limited SE psychotherapy" and perhaps the traditional, long-term psychotherapy model would elicit a higher and more frequent correlation of transference. The results "suggest that transference of interpersonal themes to the therapeutic relationship, as assessed from patients' narratives, occurs for some, but not all, psychotherapy patients." (Connolly, et al., 2000, p. 367). The researchers also concluded that while "severity of depression and quality of interpersonal relationships were predictive of individual differences in amount of transference to the therapist, other factors not investigated here may be important in explaining these individual differences." (Ibid.).

As stated earlier, these two studies represent strong support for the existence of transference, and for the belief that patients reenact in their marital relationships, issues and conflicts that were unresolved in earlier relationships, usually with parents. From this review, it can be seen that substantial empirical support exists for a relationship between transference interpretations and positive outcome in therapeutic work with individuals.

Two studies have examined countertransference. Sehl (1998) studied erotic countertransference and social work practice, and developed a survey to determine psychotherapists' (sexual) feelings, attitudes and responses. The questions posed in his study as well as the variables considered are clearly relevant to the study proposed here. Sehl developed the Erotic Countertransference Questionnaire (ECQ) which looked at social work clinicians' sexual feelings toward clients, their professional training in this specific area, clinicians'

reporting of these incidents, and the characteristics concerning therapists' backgrounds. Sehl based the items on his questionnaire from literature on countertransference. The data analysis for this study was accomplished with frequency distributions and descriptive statistics, research questions were tested with chi-square tests, independent sample t-tests, and Pearson correlations were also used where appropriate. Only correlations considered "moderate in magnitude" ($r > .30$) were emphasized.

Sehl found that gender played an important role in erotic countertransference. 21.2% of male therapists responded that they were "frequently attracted to clients" as compared with only 3.4% of female therapist respondents. One of the survey items asked, "How often have you utilized countertransferential sexual feelings to further treatment goals?". Again, the gender difference in responses was clearly significant with male therapists responding that they tended to use countertransference more often than female therapists. In terms of methodology, the questions posed were explicit and appeared to assume that respondents knew and understood the meaning of the concept. Other variables that Sehl included concerned: educational training of therapists, utilization of supervision, length of professional experience and theoretical orientation of the therapist. These variables were included separately in 5 individual questions that were presented to the respondents on the survey/questionnaire.

One of Sehl's major conclusions was that, "training with respect to transferential and countertransferential sexual feelings should be increased in social work training and post-master's training." (Ibid., p. 51). Demographic data collected in this study found that "50% of the respondents indicated they had no post-master's training and close to 20% indicated they had never been in supervision." (Ibid.). Sehl also suggests that, "Research into whether or not students' attitudes would be affected as a result of learning experiences...would be an interesting and worthwhile area of future research." (Ibid. p. 53). Studies such as this one "might open the question as to what extent training should be an emotional as well as a rational process." (Ibid.).

Mendelsohn, Bucci, and Chouhy (1992) conducted a survey concerning attitudes toward transference and countertransference in a sample of psychoanalysts. They specifically developed the ATC (Attitude Toward Countertransference) Scale for this study, and this scale "includes statements and simulated clinical situations, both of which were intended to explore different aspects of the use of the analyst's affective reactions to the patient's material in the treatment situation." (p. 369). The brief statements that were included on this scale were derived from reviewing psychoanalytic literature concerning analytic theory and technique and countertransference.

Interestingly, the results of this study demonstrated that all of the analysts supported the use of countertransference in the therapeutic interaction as a source of additional information, insight and understanding. However, the respondents' responses seemed to differ significantly where/when either their "classicist" or "totalistic" stance was reflected in their choice of response to specific items.

Among the conclusions were that there is definitely a different role, significance and understanding of countertransference, depending on whether the position of the therapist/analyst is classical or totalistic. As well, the researchers maintain that their study was effective in its design and methodology "to address...attitudinal and definitional items" (Ibid., p. 383), however they state that, "The discrepancies between attitudes towards certain aspects of technique and the frequency of their use remain to be explored." (Ibid.).

This review has confirmed that very few empirical studies have examined how therapists use countertransference. This may be related to the difficulty in accurately assessing the role that countertransference plays in therapy; however, it is likely that many therapists would agree with Sehl and Mendelsohn et al. that this is a concept that needs further study.

To summarize this section, while the psychoanalytic model has been viewed and used as a model of understanding and intervention with individuals, this model is less often applied to couples work. Research studies have been conducted to examine the effectiveness of couples

counselling, using a variety of models, but only two studies (Greenberg & Johnson, 1991; Snyder & Wills, 1989) have examined the effectiveness of a psychoanalytically based marital therapy. Both of these studies found support for the effectiveness of psychoanalytically based marital therapy.

Other research studies (but only with clients in individual treatment) have examined the presence and potency of transference as a concept originating in patients' earlier relationship patterns with significant parental/caregiver figures in the past and reappearing in present significant relationships, as in the dyadic relationship with one's mate and/or the therapeutic relationship with one's therapist. Findings have revealed that the interpersonal themes continue to carry over from the past into the present, with little or no awareness on the part of the patient. Research has demonstrated how influential the impact of past significant parental figures/ caregivers, relationships and experiences can be upon present functioning, and previous studies have investigated the detrimental consequences of unresolved conflicts originating from the past that continue to haunt patients in the present, both on an unconscious and a conscious level. Other studies have demonstrated that interpretation of transferences is associated with positive therapeutic outcome.

Few quantitative studies have focused on countertransference. The two studies reviewed here demonstrate that this phenomenon can be studied with productive results. Furthermore, the clinical literature reveals many articles on the importance of therapists being aware of countertransference (Freud, S., 1910, 1914d, 1915; Tauber, 1954; Fiscalini, 1995; Sandler, Dare & Holder, 1973; Epstein, 1977; Tansey & Burke, 1989; Maroda, 1991; Scharff, J.S., 1992; Knafo, 1999), suggesting the need for greater understanding of how therapists do understand this concept.

There is a paucity of research studies that have focused on transference and counter-transference within the psychoanalytic model. Those studies that have been done to further examine the concepts of transference and countertransference have not focused on their use in

couples counselling, nor have they focused on these concepts as therapeutic tools that may be used in the treatment of couples. This is the critical gap in both the research and the literature, which this researcher's study will begin to fill. This is an area of investigation that is pivotal to couples counselling.

The role, capability, and potency of the therapeutic use of transference and countertransference are clear; what is not clear at this point, is the extent to which social work practitioners today (1) are aware of, and (2) use awareness of these natural phenomena as efficacious therapeutic tools, that are powerful and pivotal vehicles in the therapeutic change process. This will be the objective of this research study.

Chapter 3

Methodology

This chapter begins with the purpose of this research study and a list of the major research questions that are addressed in this study. A description of the sampling and related procedures follows, as well as a description of the instrument. A review of the ethical considerations is presented, the actual data collection procedures are outlined, and this chapter concludes with a review of the data analysis, and comments regarding the face validity of the research instrument employed.

Purpose:

The topic of this researcher's study has as its focus, (a) the exploration of, and (b) the identification of practitioners' awareness, acknowledgment, understanding, and attitude (or conscious connection) concerning transference and countertransference, as well as the examination of how these practitioners (1) respond to, and (2) use these natural phenomena in their clinical practice with couples. The research instrument, the methodology in terms of research design, and the format for data collection and analysis that were developed by this researcher follow a model that is informed by the major research questions that were designed for this study, and which are outlined here.

The Research Questions: A Brief Overview:

Since this is an exploratory study, several research questions were considered to guide this study. The overarching research questions are: How do social workers and other therapists (1) perceive, and (2) use transference and countertransference in couples counselling within the psychoanalytic paradigm? Specifically, do social work practitioners and other therapists have an awareness of transference and countertransference? Are there differences between social workers and non-social workers who are therapists? Do therapists acknowledge these concepts in their

clinical practice, and how do their awareness and acknowledgment translate into practical application in the treatment of couples within the clinical realm?

Briefly, this researcher has investigated which model social workers and other therapists who counsel couples use in their work, and determined for those practitioners who identified the psychoanalytic model as useful, whether they were able to identify three of the main tenets of this specific theoretical model. The study also investigated to what degree respondents were able to apply psychoanalytic concepts to a vignette.

The concepts of transference and countertransference are described and defined according to the psychoanalytic paradigm, and considered within the context of the object relations model (Fairbairn, 1954). The major research questions were answered through the research instrument (a survey), and where applicable, the model of object relations, as clinically applied by D. E. Scharff and J. S. Scharff (1987), and J. S. Scharff (1991), was adopted by this researcher as the framework within which to score therapists' responses to various items on the survey, including open-ended questions. (See Data Analysis Section, pp. 111-112, for further details.)

The list of major research questions follows, with the items from the questionnaire categorized under each relevant research question to which they are related. Various items were combined to compose the respective key indices (i.e. of awareness, acknowledgment, understanding, attitude, and the overall index of transference and countertransference, and the index of use/practical application of the psychoanalytic model and of transference and countertransference). (For details on the combination of items that compose the scoring for each variable/key index and that correspond to each of the major research questions, as well as the weighting of individual items, see Appendix B, Coding and Scoring.)

The Major Research Questions:

1) Do social work practitioners and other therapists have an *awareness* of transference and countertransference?

   How conscious are practitioners of the presence of transference and countertransference in the therapeutic setting, and how conscious are practitioners of the existence of these natural phenomena in their own clinical practice?

   Items #12a, #14, #16a, #16b, #29, and #30

   These items were designed to gather data regarding the social workers' and other therapists' sensitivity to transference and countertransference as concepts in general, as well as concepts which are integral to their own (i.e. the practitioner's) intrapsychic functioning. Are practitioners sensitive to their own emotional reactions and subjective responses, and do they realize how their own internal functioning has implications for the therapeutic relationship?

2) Do social work practitioners and other therapists *acknowledge* transference and countertransference in their work with couples?

   Items #21, #22, #23, #24, #31, and #32

   These items were designed to gather data regarding the social workers' and other therapists' recognition of these concepts in their own practice with couples, and specifically focuses on how these practitioners might consider using these concepts as therapeutic tools in counselling the couple in the vignette.

3) Do social work practitioners and other therapists have an accurate *understanding* of these concepts?

   Items #10, #17, #18, #25, #26, #27, and #28

   This question was designed to determine whether practitioners have an accurate working definition of these concepts as well as the understanding of the potential implications of these concepts in terms of their use within the therapeutic context. There is a greater probability that practitioners who do not have an accurate identification, definition, and understanding of these concepts would either not be using them or using them incorrectly within their practice.

4) What is the general *attitude* of social work practitioners and other therapists, regarding transference and countertransference?
   Sub-Research Question: Do social work practitioners and other therapists view these concepts as useful in their clinical practice?

   Items #13, #15a, #19, and #20

   These items were designed to identify the attitudes of social workers and other therapists, in terms of whether they perceive transference and countertransference as helpful

concepts or hindrances, and how do practitioners' perceptions influence how they would or would not use these concepts in their work?

5) Do social work practitioners and other therapists *apply* these concepts appropriately to a clinical vignette?

Items #9a, #9b, #11a, #11b, #11c, #12b, and #15b

A lack of understanding and/or misunderstanding of these natural phenomena can lead to a missed opportunity, in terms of potential efficacious tools for diagnosis, assessment, and intervention within the clinical realm.
Misuse of these natural phenomena as therapeutic tools can lead to negative implications, both for the practitioner and the patient/patient couple.

A coding scale has been developed that will provide a "match" between practitioners' understanding of these concepts (as expressed through responses requiring their knowledge of these concepts) and how they assess the most problematic issue(s) for the client couple in the vignette. It is expected that there will be a high correlation between practitioners who respond appropriately with accurate responses to the close-ended questions and their assessment of the couple in the vignette. Respondents who score highly on the close-ended questions but who do not make an appropriate nor accurate assessment would demonstrate their lack of understanding of these natural phenomena and their inability to recognize, identify, and use them appropriately.

6a) Do practitioners *consider* the *usefulness of the psychoanalytic paradigm* as both a model of understanding and as a model of intervention, when treating couples? Is this their model of choice or preference? Is the psychoanalytic model even a consideration when they contemplate various other theoretical frameworks?
b) Is the object relations model (Fairbairn) applicable as a model of understanding and intervention in couples counselling, as applied by Scharff and Scharff?

Items #9a, #9b, #11a, #11b, #15a, and #15b

Variables such as gender, educational background, training, and years of experience, as well as (access to) supervision will be considered as influential factors that may be associated to how knowledgeable, informed, and receptive a practitioner is, in terms of considering and using the psychoanalytic model as a model of choice when counselling couples, including the couple in the vignette.

7) Do practitioners *identify* the presence of *transference and countertransference* within the case vignette, and if so, how would they use these as therapeutic tools? Would they view them as therapeutic tools that can be efficacious in the intervention/treatment of this specific couple?

Items #11b, #11c, #33, and #34

A coding system and a scale have been developed that provide a "match" for respondents who demonstrate through their responses to the general questions that they do have a knowledge and an understanding of these concepts, and who then demonstrate their skills

through an identification of these concepts in the vignette. Additionally, these practitioners would continue to score at a "high level" since they would apply these concepts in their assessment of the couple.

For example, a scale has been developed that will rate each respondent on a High or Low level of knowledge and understanding of transference and countertransference, based on how they respond to both the close-ended and open-ended questions. Additionally, these respondents are scored on their application of these concepts to the clinical case presented in the vignette. The results of how each respondent scores are presented as the model of either "a good match" or "a poor match", with a clear demonstration of how the x variables influence the y.

8) Do gender, training, theoretical orientation, years of experience, or use of supervision affect awareness, understanding, attitudes, and appropriate application of transference and countertransference?

   Items #1 through #8 inclusive

   The demographic data here provide a foundation upon which the practitioner's knowledge base, skills, attitude, understanding, and clinical application are predicated.

Please see Appendix C, Summary of the Research Questions, for details regarding responses to these research questions.

Design of the Research:

The design selected was an exploratory survey. A cover letter/letter of information (Appendix D, Cover Letter/Letter of Information [General] and Appendix E, Cover Letter/Letter of Information [O.A.S.W.]) was mailed out to potential respondents, inviting participation in this study. A cover page (Appendix F, Cover Page) was the first page of the questionnaire package, followed by an instruction page (Appendix G, Instruction Page), both of which were attached to the questionnaire (Appendix H, Research Instrument/Survey Questionnaire). A vignette (Appendix I) accompanied the questionnaire, as well as a "Free Gift" flier (Appendix J), and a Thank-You note (Appendix K, Thank-You Note) to thank participants for their consideration of, and potential participation in this study. Additionally, a self-addressed, postage-paid return envelope (Appendix L, Self-Addressed, Postage-Paid Return Envelope) was enclosed, for

participants to mail back their completed questionnaire. A further description follows, concerning all of the materials mailed to potential respondents. Additional details may be found in the corresponding appendices.

This researcher examined the knowledge base and perceptions of practitioners, based on their self-reporting through the use of a questionnaire that included both open and close-ended questions. A total of 51 variables (e.g. education, years of practice as a clinical social worker/therapist/counsellor, type of theoretical model of choice found Most Useful when working with couples, most influential source of data identified by respondent in assessment, etc.) were examined through the use of this questionnaire. (See Appendix M, Variables Directly from the Questionnaire, and those Variables Calculated from this List.)

A pilot study was conducted prior to the mailing of the questionnaire to the population of potential respondents, in order to check clarity, wording, spacing, and other technical details of the questionnaire. The questionnaire was test-administered to 10 practitioners (6 social workers and 4 non-social workers) who were not included in the actual research study. These practitioners were colleagues who had an interest in this research study, and who had offered to be volunteers in the pilot study. Minor revisions were made to the questionnaire, based on the feedback received from these practitioners. The questionnaire was then mailed, accompanied by a vignette, cover letter, etc. (For further details, see Appendix N, Mailing and Data Entry Procedures.)

The vignette, which accompanied the questionnaire, had been designed to include several examples of transference and countertransference for the respondent to identify, and on which to comment. The respondent was expected to identify the presence of both transference and countertransference, thus demonstrating his/her awareness of these concepts within the therapeutic context. Additionally, the respondent was asked to accurately define these concepts in order to demonstrate his/her understanding of them, and then to appropriately apply these concepts as useful therapeutic tools in his/her diagnosis and treatment plan for the couple

presented in the vignette. (See Major Research Questions, pp. 99-101, and Appendix B, Coding and Scoring, for further details.)

The survey, which had an attached cover page advising potential respondents of an incentive free gift and early bird draws (See Appendix F, Cover Page), and an instruction page advising potential respondents how to complete the questionnaire (Appendix G, Instruction Page), as well as a cover letter/letter of information (Appendix D, Cover Letter/Letter of Information) was mailed to potential respondents who comprised a representative sample of social work practitioners and other therapists in Ontario. A separate cover letter/letter of information was mailed, which had been specifically designed for O.A.S.W. members, at the request of the Executive Director. (See Appendix E, Cover Letter/Letter of Information [O.A.S.W.]). The cover letter/letter of information invited potential respondents to participate in this research study. (See Sampling and Procedures Section for details, p. 104.) A free gift was offered to respondents, for responding to the survey and mailing back the completed questionnaire, as well as the opportunity to be entered in an Early Bird raffle or raffle(s); these were offered as incentives to encourage a higher response rate. (See Appendix O, Incentive Raffles and Free Gifts to Respondents, Response Rates, and Respective Due Dates for further details.) A "free gift" flier was also included (Appendix J, Free Gift Flier), advising participants that they would receive their complimentary gift as a "thank you" for responding to the study, and offering additional information. The cover letter/letter of information for respondents outlined details regarding the research study, ethical considerations including the assurance of anonymity and confidentiality, participation prizes, early bird raffles, and follow-up phone calls. As previously stated, a "thank-you" note was included to thank the respondent in advance for his/her consideration to participate in this study, and a self-addressed, postage-paid envelope was also included in order for the respondent to mail back his/her completed questionnaire. While every attempt was made to avoid duplicate questionnaires being sent to the same respondents, potential respondents were advised

in the cover letter to return an additional copy of their questionnaire with "Duplicate" written on it, in the event that they received more than one.

A "thank-you" letter was also sent to all respondents along with their incentive "thank-you" gift, for those respondents who had participated in this study and completed their form to receive their gift. (See Appendix P, Thank-You Letter to Respondents to Accompany Incentive "Thank-You" Gifts.)

Sampling and Procedures:

The sample of respondents included the membership pool of three large professional organizations: (1) the Ontario Association of Social Workers (O.A.S.W.), (2) the Ontario Association for Marriage and Family Therapy (O.A.M.F.T.), and (3) the Ontario College of Social Workers and Social Service Workers (O.C.S.W.S.S.W.). The criterion for inclusion in the sample for this study was membership in one of these organizations. All respondents who reported having some experience with couples counselling are included in the sample. As well, members who work within the academic realm as long as they also engage in clinical practice with individuals and/or couples, are included in the sample, to allow for a brief discussion of this smaller group. Although the major focus of this research study is on the use of transference and countertransference by social work practitioners, the collection of non-social work practitioner data will allow a comparison of social workers versus non-social workers (referred to in this study as "other therapists").

For purposes of this research study, "couples counsellors" will be referred to generally as "practitioners", and these terms may be used interchangeably. These practitioners are defined as those who treat/work with couples. Social work practitioners will be referred to as "social workers", and are defined as those practitioners who hold either a B.S.W. or an M.S.W. degree, or both of these degrees. Other helping professionals who are non-social work practitioners (i.e. therapists/counsellors) will be referred to as "other therapists", as previously noted, and are

defined as those practitioners who hold a degree other than social work, and who are in clinical practice, treating/working with couples.

Previous research studies (Kenyon, 1997) have utilized the database of the Ontario Association of Social Workers (O.A.S.W.), to obtain a sample of respondents from the field of social work. While the present membership consists of 3,136 members, nevertheless this sample alone would be limited in that it would include those social workers who had voluntarily chosen to belong or who could afford the membership fees of the association. As well, included in this membership list are non-practising social workers, who were removed from our research sample, which has, as its focus, social workers who are presently employed in clinical practice. The data base from the Ontario Association for Marriage and Family Therapy (O.A.M.F.T.), which is comprised of 740 members, was also utilized; this membership consists of social workers and other helping professionals who are non-social work practitioners (i.e. therapists/counsellors), who are currently employed in clinical practice and who work with individuals and/or couples. In fact, members of the Ontario Association for Marriage and Family Therapy are known to specialize in couples counselling/marital therapy, and most of their members treat couples. Additionally, since this research study sought to explore a broader population of practitioners who treat couples, a membership list was obtained from the Ontario College of Social Workers and Social Service Workers (O.C.S.W.S.S.W.), the regulatory body for social workers and related practitioners registered in Ontario. Since registration and membership are required by law in order for a practising social worker to use the title/designation "social worker", and to practise in the capacity of social worker in Ontario, a substantial list of social workers/therapists/counsellors (8,000) was obtained from this organization.

The Ontario College of Social Workers and Social Service Workers has 8,853 members, 853 of whom are social service workers. A list of 8,000 members was obtained from the O.C.S.W.S.S.W. (the members classified as social service workers had been removed). This list was drawn from members registered under the category of "Social Worker". These members

possess either a social work degree or a related academic degree, and hold either a General Social Work certificate or a Provisional Social Work certificate. This O.C.S.W.S.S.W. list of 8,000 was closely examined, and duplicate names and addresses as well as incomplete addresses were removed from this list, leaving a revised list of 7,667 members. The O.C.S.W.S.S.W. list (7,667) was merged with the O.A.M.F.T. list (740) with a resulting list of 8,207, after which duplicate names were removed and a random sampling procedure employed to select potential respondents for this study. While a very large sample, almost encompassing the entire population of social workers and other therapists in Ontario, was used for this study, a random sampling procedure was employed to select potential respondents. (For a more detailed explanation, including the technical aspects of this random sampling procedure, see Appendix Q, Random Sampling Procedure). Since members of the O.A.S.W. may also be registered members of the O.C.S.W.S.S.W. (and of the O.A.M.F.T.), the issue of duplication needed to again be addressed. The merged O.C.S.W.S.S.W. and O.A.M.F.T. lists and the O.A.S.W. list were cross-referenced, and all duplicate names of members were then removed. After the random sampling procedure took place, we were left with a list of 7,100 potential respondents for this study. Since this researcher sought to obtain a large enough sample of couples counselling practitioners to be representative of social work and non-social work practitioners (i.e. other therapists) in Ontario, it was decided that this list of 7,100 practitioners would be the sample surveyed, and the respondents from this sample would be the basis of our study.

A total of 7,100 surveys/questionnaires was mailed to the selected members of the O.C.S.W.S.S.W., the O.A.M.F.T., and the O.A.S.W. (The technical details of the mailing and data entry can be found in Appendix N, Mailing and Data Entry Procedures.) The return rate/response rate was 1,401 (19.7%), which was well within the range conducted by previous mailed surveys/questionnaires in this faculty (Social Work) and in published research studies. Of these, 941 (67.2%) completed surveys/questionnaires were determined to be useable. A more

detailed discussion of the response rate, breakdown of useable questionnaires, and the respondents included in this sample will be outlined further in the Results section (Chapter 4, pp. 115-116, Response Rate) of this dissertation.

Instrument:

A survey instrument was designed as the source of data, and included 51 variables that cover a number of dimensions. The data is primarily quantitative, with a secondary qualitative component that includes several open-ended questions. The questionnaire begins with general questions designed to obtain demographic data including gender, academic degree, year of graduation, and years of experience. Additional general questions and more specific questions were developed from the literature concerning couples counselling, transference, and countertransference. The two theoretical frameworks that were specifically selected to test the research questions and hypotheses, include the psychoanalytic paradigm and the object relations model (which is psychoanalytic). Additionally, several previous research studies similar to this particular study, addressed variables of significance, which were also included for examination in this study (Mendelsohn, Bucci, & Chouhy, 1992; Sehl, 1998).

A number of factors were examined, including level of education, years since graduation with highest degree, years of experience with highest degree, and years of previous clinical experience. A scoring system was developed to determine how well respondents scored on various items that indicated variables of awareness of, acknowledgment of, attitude toward, understanding of, and use/practical application of transference and countertransference, and use of the psychoanalytic model. (See Appendix B, Coding and Scoring.)

The instrument, which was a survey/questionnaire, was accompanied by a vignette. This vignette has been designed to include several examples of transference and countertransference for the respondent to identify and on which to comment. The respondent was asked to identify the presence of transference and countertransference, thus demonstrating his/her awareness of

these concepts within the therapeutic context. Additionally, the respondent was asked to accurately define these concepts in order to demonstrate his/her understanding of them, and then to appropriately apply these concepts as useful therapeutic tools in his/her diagnosis and treatment plan for the couple presented in the vignette. (See Research Questions and Data Analysis Sections in this chapter for further details.)

Ethical Review:

All prospective participants were sent a letter of information in the form of a cover letter by the researcher, along with the survey/questionnaire and vignette. The cover letter/letter of information introduced the researcher and offered a brief introduction to the research study, and also invited the social worker/therapist/counsellor to be a participant in this study by completing and sending back the questionnaire by the (choice of) date(s) specified.

Informed consent was addressed through the detailed cover letter, which outlines the purpose of the research study and uses of the collected data. It is important to note that current practice regarding this type of research instructs that a consent letter is not required in a mailed-out survey/questionnaire. The completion and mailed return of the questionnaire indicates the consent of the respondent. This process was reviewed and approved by the Wilfrid Laurier University Research Ethics Board.

Confidentiality, anonymity, and privacy were assured and maintained throughout the research study. There was no identifying information that could be obtained from the data collected through the questionnaires, or in the findings of the research study. There was no identifying information on the questionnaires other than a code number on the cover sheet. A follow-up telephone call was included (See Appendix R, Follow-Up Telephone Call Script) as a reminder to respondents, to encourage a higher return/response rate. The assigned code number was to facilitate the follow-up telephone call during the initial part of the process. Additionally, this assigned code number was used for entrance in the raffle/draws, after which all identifying

information was destroyed. Only the researcher and her assistants had access to the data, for purposes of data entry.

Two individuals were selected to be judges/raters for inter-rater reliability, but they did not have access to any of the participants' names or other identifying information; they reviewed only unidentifiable/anonymous specific responses on the questionnaire, for evaluation and coding purposes.

Additionally, the printer and printing staff received only the order forms with participants' names, addresses, and telephone numbers, for the sole purpose of printing their orders for either professional cards or personalized stationery, which was the complimentary gift for respondents as indicated by the respondents. However, the order form was a separate sheet that was not attached to the questionnaire, and after the printer and printing staff had completed reviewing the orders that were to be filled and mailed, all free gift order forms were destroyed along with any other files or records of respondents (including electronic files).

All submitted proposals and accompanying materials for ethical review were approved by all three participating professional organizations (See Appendix S, Write-Up of Individual Presentations to Professional Organizations for Proposal Review), in addition to the Faculty of Social Work, and the Research Ethics Board of Wilfrid Laurier University. A presentation and submission were successfully made to a family service agency, the Metropolitan Toronto branch of the Children's Aid Society, in order for this agency to release questionnaires that had been previously mailed to its employees. Upon a review of the proposal for this study, and a follow-up presentation given by this researcher, the questionnaires were released by this agency to the recipients who had been randomly selected as part of the list of potential respondents. (See Appendix T, Write-Up of Individual Presentation to a Family Service Agency for Proposal Review.)

All completed questionnaires and related information were kept secure, under lock and key, in this researcher's office when not in use, and at the completion of this research study all completed questionnaires and rough materials related to this study were destroyed.

Procedure for Data Collection – Sources and Methods:

Mailing lists were provided by the three professional organizations, and mailing labels were provided for the envelopes being mailed to O.C.S.W.S.S.W. members by the O.C.S.W.S.S.W. The mailing house contracted by this researcher provided the mailing labels for envelopes being mailed to the remaining members (i.e. for the O.A.M.F.T. and the O.A.S.W. members), and this researcher and her research assistant addressed some envelopes by hand.

Once the sample was determined, duplicate names and addresses were removed to avoid accidental mailing of duplicate questionnaires.

Respondents were also offered a copy of the findings, once the research study was completed, as outlined in the cover letter/letter of information. As previously stated, each questionnaire package was mailed with a cover letter/letter of information and a postage-paid, self-addressed envelope. All surveys/questionnaires were mailed on March 31st, 2003, with three separate requested response dates indicated that corresponded to the incentive draws for respondents who chose to be entered in the various draws. All respondents received a free gift of either professional cards or personalized stationery, simply for responding to the survey and mailing it back by April 28th, 2003, the last due date/deadline specified. (See Appendix J, Free Gift Flier.) Since several respondents contacted this researcher to request an extension for the due date, the due date was extended to May 16th.

Upon opening each envelope, the researcher and her assistant immediately separated the coded cover sheet from the completed questionnaire, thereby ensuring anonymity of responses. Codes were then noted on the master list for purposes of follow-up. The coded cover sheets were placed

in two different, clearly labelled boxes in preparation for the incentive draws. (For further details, see Appendix N, Mailing and Data Entry Procedures.)

During the month of April, 2003, two research assistants and the researcher telephoned as many non-respondents in the sample as possible, to remind and encourage them to participate in the study. As well, a reminder e-mail note was sent out to all potential respondents (i.e. members of the O.A.M.F.T. and of the O.A.S.W.) for whom e-mail addresses had been provided. (See Appendix U, Reminder E-Mail Message for Respondents – General, and Appendix V, Reminder E-Mail Message for Respondents – O.A.S.W.) The assigned code number found on the cover page for each questionnaire facilitated the follow-up telephone call during the initial part of this process.

The incentive draws were conducted on June 11th, 2003. A congratulatory letter was mailed to all raffle prize winners as well as a telephone call made, to advise the winners. (See Appendix W, Raffle Prize Winner Congratulatory Letter.)

All close-ended responses were entered into SPSS by two research assistants and the researcher. This data was transformed by a research assistant for analysis using SPSS. Qualitative data were recorded by two research assistants and the researcher, and analyzed for themes by the researcher.

Data Analysis:

Descriptives in the form of frequencies are reported as well as any significant correlations, in addition to any observations considered to be conceptually relevant. (See Appendix X, Data Analysis Techniques – Detailed.) Included with the descriptives is an overview of the scoring for the sample of couples counsellors, and a more detailed overview of the scoring for social workers who do couples counselling and other therapists who do couples counselling, on awareness of transference and countertransference, acknowledgment of transference and countertransference, understanding of transference and countertransference, attitude toward transference and

countertransference, and use of the psychoanalytic model and of transference and countertransference, as well as on the overall index. (See detailed explanation of Scoring of the Indices and additional related comments in Appendix B, Coding and Scoring.) The relationship of demographic variables to scores on these key variables/key indices is also examined and reported.

The last two items on the questionnaire are explicit, and the respondent was required to address whether or not he/she uses transference and countertransference in his/her clinical practice. Having answered all of the previous questions in the survey, these last two items (#33 and #34) can be viewed as a measure of internal consistency, which will confirm the respondent's previous selected responses or contradict them. Reliability can be tested through the responses to the open-ended questions where there is rank-ordering, and from a coding scale that was developed by the researcher to identify key concepts or terms that demonstrate the respondent's knowledge, understanding, and application.

The model of object relations (Fairbairn, 1941), as clinically applied by Scharff and Scharff (1991), was adopted by this researcher as the framework within which to score respondents' responses to various items on the survey. (See Appendix B, Coding and Scoring.) Using the researcher's coding system, two other judges/raters were trained to independently evaluate the responses. Inter-rater reliability was then established, by correlating the researcher's responses with the other raters' responses. (See Chapter 4, Inter-rater Reliability.)

Quantitative data was analyzed, using t-tests, One-way ANOVA F-test and Fisher's LSD tests, crosstabulations in a contingency table, and a Linear Regression model. The results of t-tests are presented to demonstrate the comparison of social workers and non-social workers (i.e. other therapists) across relevant variables, and crosstabulations are outlined that demonstrate the relationship between practitioners' theoretical knowledge and their practical application. A linear model is presented for predictors of practical application/use of transference and counter-transference. Finally, issues related to validity and reliability are reviewed.

Face Validity:

Face validity of the research instrument was determined by the doctoral dissertation committee, composed of academics with clinical practice experience, and who have expertise in the fields of psychoanalytic/psychodynamic theory, individual and couples counselling, research, and academe. The research instrument was determined to have good face validity.

Chapter 4

Results

This chapter is divided into seven sections. A brief summary of the response rate from the overall/total sample surveyed will initially be presented. (A more detailed overview of the basic descriptive statistics for this overall sample across several variables can be found in Appendix Y, Overview of Overall Sample, for the interested reader). Since the focus of this research study is the use of transference and countertransference by social work practitioners and other helping professionals who counsel couples, participants who met this criteria comprise the subsamples that will be examined in detail. The first section presents a brief overview of the couples counselling sample (n = 654), referred to as the primary sample. (A more detailed examination of the couples counselling sample including basic descriptive statistics for this sample across several variables can be found in Appendix Z, Overview of Couples Counsellors Sample.) The 532 (81.3%) social workers and the 122 (18.7%) other therapists comprise this couples counselling subsample, and are the primary focus of our analysis. (See Figure 1 for a pictorial display of the primary sample breakdown.) An overview of the subsamples of social workers and other therapists who counsel couples will be presented in the second and third sections respectively, and a comparison of these two groups will be included in the fourth section.

A contingency table using crosstabulations to determine the degree of consistency of theoretical knowledge with practical application is outlined in Section 5. Section 6 presents a linear model, which demonstrates an examination of predictor variables for the vignette score for practitioners who counsel couples.

In Section 7, we will briefly discuss the following 2 groups: (1) practitioners who work within the academic realm and who are also engaged in clinical practice, and (2) those practitioners who are psychoanalytically oriented.

The coding and scoring system, which has been developed by the researcher, is briefly

explained here to facilitate the reader's understanding of the scoring system, how it relates to each individual major research question for this research study, and how the various subsamples perform in terms of their scores on these variables. Each item on the questionnaire was categorized under one of the major research questions, and each item was also included in a combination of items for each key index (i.e. awareness, acknowledgment, understanding, attitude, the overall index, and use/practical application of transference and countertransference). Each of the indices was based on one of the major research questions (See Ch. 3, pp. 99-101); and each index was scored out of 10. (For details on the combination of items that compose the scoring for each variable and that correspond to each of the major research questions, as well as the weighting of individual items, see Appendix B, Coding and Scoring.)

Response Rate:

A total of 7,100 surveys/questionnaires were mailed out to potential respondents who were previously selected members of the following three professional organizations, using a random sampling procedure: the Ontario College of Social Workers and Social Service Workers (O.C.S.W.S.S.W.), the Ontario Association for Marriage and Family Therapy (O.A.M.F.T.), and the Ontario Association of Social Workers (O.A.S.W.). The return/response rate was 1,401 (19.7%), which was well within the range conducted by previous mailed surveys/questionnaires in this faculty (Social Work) and in published research studies. Of these, 941 (67.2% of those mailed back) completed questionnaires were determined to have been completed by "Clinical" professionals (who currently treat couples and/or individuals) and were therefore useable for our research sample. The completed questionnaires from these 941 respondents were used for analysis, and the results, which follow in this chapter, are based upon the data collected from these 941 respondents. Two hundred and twenty-six (16.1%) mailed back questionnaires were determined to be Non-Clinical and could therefore not be included in our sample, another 143 (10.2%) were identified as Non Useable/Rejected, 50 (3.6%) had been returned by the post office

as Undeliverable/Return to Sender, 22 (1.6%) were Non-Participating and 19 (1.4%) were Duplicates. (For further details, see Appendix AA, Identification and Classification of Questionnaires Mailed Back from Respondents.)

Inter-Rater Reliability for Open-Ended Questions Related to the Vignette:

Two raters were trained to code and score the open-ended questions on the questionnaire, which were associated with the vignette. Items #11b, #12a, #12b, #16a, and #16b were the open-ended questions requiring inter-rater reliability with 80 - 85% reliability considered to be adequate. It may be noted here that Item #9b may also be considered an open-ended question. Both raters attained 95% inter-rater reliability with the researcher, after the conclusion of their training period. (For further details regarding the training process and procedures involved for inter-rater reliability, see Appendix BB, Inter-rater Reliability.)

Overall Reliability of Research Instrument:

An overall test of consistency was performed for the overall reliability of the questionnaire. The overall sample of respondents (n = 941) was used, to obtain the largest sample and the strongest reliability possible. The following (21) items were selected because they all relate to transference and countertransference (i.e. definitions of, subjective feelings, internal reactions) and the psychoanalytic model, and were close-ended items: #10, #13, #14, #15a, #15b, #19, #20, #21, #22, #23, #24, #25, #26, #27, #27, #28, #29, #30, #31, #32, #33, and #34. The Cronbach's Alpha = .792 (n = 773), which is well within the acceptable limits for academic research.

Factorial Validity:

Combinations of major variables were examined through a factor analysis (using SPSS Default Factor Analysis), incorporating a Varimax rotation method. As can be seen in Table 1, more than 70% variance was accounted for by the groups of variables listed.

Table 1

Factorial Validity

Groups of Variables (Items)	Number of Questions	Components Extracted	% Total Variance Accounted for by these Items
Countertransference-related	6	3	77.2
Transference and Countertransference-related	6	3	90.6
Index of Awareness	5	3	77.3
Index of Acknowledgment	6	2	71.5
Index of Understanding	6	3	83.6
Index of Attitude	4	2	70.0

Reasonable construct validity for this type of research was demonstrated by this questionnaire. These results were consistent across the overall sample, the couples counsellors samples, and the social workers subsample. Excluded from some of the major indices' variable groupings (in Table 1) were items that were open-ended, or those items that did not relate to transference, countertransference or the psychoanalytic model. The index of use/practical application was not tested due to the nature of this index; important items in this index are open-ended. In summary, the factorial validity was good.

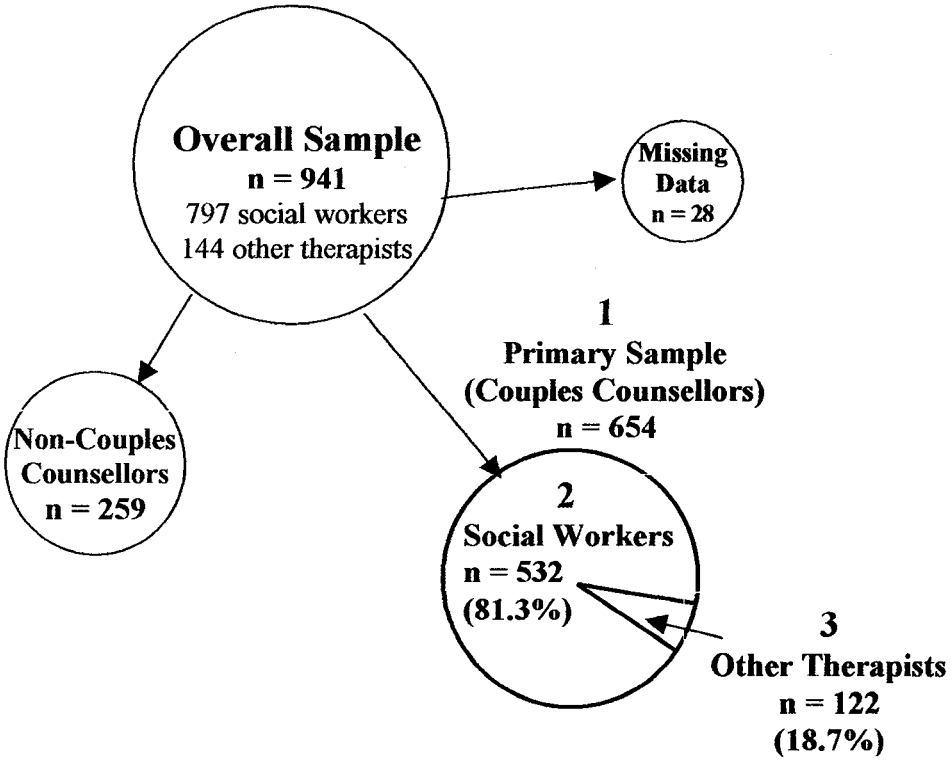
Internal Consistency:

Four tests were performed to test the internal reliability of respondents' answers. A contingency table in the form of crosstabulations was produced for this purpose. In each test, the respondents' answers to two almost identical questions, which had been purposely placed in different locations on the questionnaire, were compared for consistency. The protocol for judging consistency through crosstabulations is outlined as follows: Each of the items compared was reduced to and classified by two levels (i.e. correct and incorrect). These items were compared using crosstabulations and were determined to be consistent if a respondent chose either "correct" for both items or "incorrect" for both items. If a respondent chose "correct" for one item and "incorrect" for the matching item, this match was determined to be inconsistent.

All four tests produced similar results in the form of responses to the specified items. The items identified and employed for these tests were: #21 with #33, #23 with #33, #24 with #34, and #22 with #34. (n ranged from 904 – 911). Each test for reliability was 85% - 86% consistent, with 14% - 15% being inconsistent. This high level of consistency proved the reliability of the respondents' answers to be more than adequate for inter-consistency reliability, according to accepted research standards.

Figure 1

Overall Sample:



Overall Sample:

As can be seen in Figure 1, the total number of respondents in the overall sample was 941, which was comprised of 797 (84.7%) social workers and 144 (15.3%) non-social workers (i.e. other helping professionals classified as therapists/counsellors).

Since the major focus of this research study was couples counsellors who are social workers and other therapists, referred to as the primary sample in this research study, this will be the

sample to be examined and discussed in detail here. The primary sample shares many of the characteristics with the overall sample and is a reflection of this larger group. (For further information, please refer to Appendix Y, Overview of Overall Sample).

Both social workers and other non-social work practitioners who treat couples were studied, in terms of how they view, understand, and work with couples in their clinical practice. Both groups (social work and non-social work practitioners/other therapists) were assessed in terms of how their theoretical and conceptual understanding of transference and countertransference are translated into clinical practice. As well, the attitudes, perceptions, and practice of practitioners were explored through the lens of the psychoanalytic model; more specifically, the object relational perspective.

We will now turn our attention to the main focus of this research study: the primary sample of couples counsellors, comprised of both social workers and other therapists. A brief overview of this primary sample follows, outlining similarities between social workers who treat couples and other therapists who treat couples, after which a more detailed examination of each subgroup will be introduced.

1. <u>Primary Sample (Couples Counsellors):</u>

As seen in Figure 1 (p. 118), the total number of respondents in our primary sample of practitioners who engage in couples counselling is 654, comprised of 532 (81.3%) social workers and the remaining 122 (18.7%) respondents who are other therapists. The vast majority of respondents in the couples counselling sample is comprised of social workers. No significant differences between couples' counsellors as a whole and social workers who counsel couples on the vast majority of variables were recorded in this survey. This is not surprising since the majority of respondents (81.3%) sampled were social workers.

There are many similarities between the couples' counsellors sample, the social workers sample, and other therapists sample, most notably between couples counsellors and social workers

who counsel couples. In comparing demographic variables on the six key indices, examples of similarities shared by couples counsellors and social workers who counsel couples include the following variables: gender (Item #1) where the majority of couples counsellors is female (72.7%) and the majority of social workers is also female (74.7%); the number of couples currently treated (Item #6b) where couples counsellors treated an average of 24.9 couples per year and social workers treated an average of 24.1 couples per year; length of treatment (Item #7c) where the most popular choice selected among respondents was 1 - 10 sessions for both (72.4%) couples counsellors and (72.4%) social workers; and theoretical orientation where 6.1% couples counsellors and 5.7% social workers chose the psychoanalytic model.

One of the few observable differences between these two groups can be found in current employment setting (Item #5a) where, although the largest number of respondents from both samples indicated private practice, more couples counsellors (30.0%) selected this response than social workers (24.5%). Another observable difference was found in the selection of theoretical orientation (#9a) where 17.4% couples counsellors chose Systems as compared with 14.4% social workers.

For purposes of brevity and clarity, the sample of social workers who counsel couples will be the focus of this study, and a comparison will be made with the sample of other therapists (non-social workers) who treat couples in the next sections. To increase the potency of the tests for significance and overall reliability, the couples counsellors sample has been occasionally utilized because it provides a larger number of respondents. (For further information or further comparisons regarding the couples counsellors sample, see Appendix Z, Overview of Couples Counsellors Sample).

2. <u>Social Workers who do Couples Counselling:</u>

As displayed in Figure 1, the total number of social workers who treat couples is 532 or 81.3% of the primary sample. This section reports the significant relationships found between

variables and the six key indices previously described.

Gender (Item #1) and the Key Indices:

This sample of respondents who are social work practitioners who treat couples, is comprised of a majority of female respondents. (Table 2).

Table 2

Gender (Item #1) (n = 530)

Male	Female
134 (25.3%)	396 (74.7%)

*missing data = 2

T-tests were performed, and no significant differences were found; there were no gender differences, in terms of scoring on the key indices.

Education (Item #2) and the Key Indices:

Table 3 illustrates the breakdown of degrees for this subsample of social workers who treat couples. Of these 532 social workers, most have their M.S.W. degree.

Table 3

Education (Item #2) (n = 532)

Degree	n	%
B.S.W.	94	17.7
B.S.W. & M.S.W.	153	28.8
M.S.W.	285	53.6

*missing data = 0

Included in the above table were practitioners who also had the following degrees:
21 Social work-related certificate
6 Psychology-related certificate
10 Psychoanalytic certificate/training
9 OAMFT/AAMFT clinical members/supervisors
11 Ph.D. in social work
1 Ph.D. in Psychology
4 Ph.D. in other field

Year of Graduation and the Key Indices:

Table 4 presents a comparison of social work practitioners with their M.S.W. degree and years of graduation, and their scores on the key indices.

Table 4

Year of Graduation with M.S.W. Degree (in Decades) and Key Indices

Decade of Graduation	n	Awareness Index	Acknow-ledgment Index	Understanding Index	Attitude Index	Overall Index	Use Index
1960	26	5.32 S.D.= 1.39	6.35 S.D. = 2.57	4.95 S.D. = 2.15	7.56 S.D. = 1.59	6.04 S.D. = 1.25	1.72 S.D.=.94
1970	79	5.80 S.D. =1.59	6.35 S.D. = 2.81	5.24 S.D. = 1.75	6.96 S.D. = 2.01	6.09 S.D. = 1.34	1.85 S.D.=1.63
1980	129	5.60 S.D. = 1.81	6.33 S.D. = 2.42	5.25 S.D. = 2.00	6.94 S.D. = 1.62	6.03 S.D. = 1.30	1.35 S.D.=1.09
1990	147	5.65 S.D. = 1.68	6.21 S.D. = 2.61	5.50 S.D. = 2.00	6.96 S.D. = 1.79	6.08 S.D. = 1.23	1.56 S.D.=1.23
2000	48	5.45 S.D. = 2.06	6.49 S.D. = 2.61	5.21 S.D. = 1.68	7.11 S.D. = 1.67	6.06 S.D. = 1.35	1.34 S.D.=1.19

As can be seen in Table 4, respondents who were trained and graduated with their M.S.W. degrees in the 1960s had the highest mean score on attitude. Of interest to note, the second highest mean score on attitude was attained by those respondents who were trained and graduated in the 2000s. Additionally, respondents who were trained and graduated in the 1960s had the second highest mean score on use/application; the highest mean score on use/application was attained by respondents from the 1970s. Respondents who were trained and graduated with their M.S.W. degrees in the 1970s had the highest mean score on awareness, overall index (marginal) and use; the second highest mean score on awareness was attained by those respondents who were trained and graduated in the 1990s.

ANOVA tests were performed to investigate differences on the key indices. Differences on awareness were not statistically significant, although respondents who were trained and graduated with their M.S.W. degrees in the 1970s attained the highest mean score on awareness in comparison with respondents from the other decades (See Table 4). Only differences on

use/application proved to be significant where F(4, 424) = 2.36, p = .053 (Table 5).

Fisher's LSD (multiple comparison) test demonstrated that respondents who graduated with their M.S.W. in the 1970s scored significantly higher on use/application than those who graduated with their M.S.W. in the 1980s, and those who graduated with their M.S.W. in the 2000s. (See Table 5).

Table 5

LSD Test Comparing Mean Differences of Decades of Graduation Based on Scoring on **the Index of Use of the Psychoanalytic Model, and of Transference and Countertransference**

Higher Scoring	mean	Lower Scoring	mean	Mean Difference	p
M.S.W. in the 1970s	1.85	M.S.W. in the 1980s	1.35	.50	.006
M.S.W. in the 1970s	1.85	M.S.W. in the 2000s	1.34	.51	.029

Area of Specialization in M.S.W. Programme:

As would be expected, the majority of social workers in this sample identified their area of specialization in their M.S.W. programme (Item #2) as "individuals, family and groups", with the next largest number of respondents identifying their area of specialization as "community practice/ community organization". (Table 6)

Table 6

Area of Specialization in M.S.W. Programme (Item #2) (n = 438)

Area of Specialization	n	%
Individuals, family and groups	364	83.1
Community practice/Community organization	12	2.7
Other	62	14.2

*missing data = 0

An ANOVA test was performed to compare the difference in mean scores on the key indices across the areas of M.S.W. specialization (See Table 6), and no significant differences were found.

Present and Previous Professional/Employment Experience (Item #3b):

All respondents (n = 532) indicated "presently working as a clinical social worker/therapist/counsellor" as their response on this item, and the majority had previously worked in this capacity. (See Table 7).

Table 7

Previously Employed as a Clinical Social Worker/Therapist/Counsellor (Item #3b) (n = 487)

Previously employed	Not previously employed
444 (91.2%)	43 (8.8%)

*missing data = 45

A t-test was performed to compare those social work practitioners who had previous professional experience as a clinical practitioner with those who did not (Table 7), to determine whether or not previous clinical experience was influential on scoring on the key indices, and no significant differences were found.

Majority of Client Systems Treated in Previous Professional/Employment Experience (Item #3c):

The majority of client/patient systems treated by respondents in the past, as indicated by the majority of respondents in the sample, was "individuals". The second largest number of respondents had indicated "couples" as the majority of client/patient systems they had treated in their previous clinical experience. (Table 8)

Table 8

Previous Client/Patient Systems (Item #3c) (n = 456)

Individuals	Couples	Families	Groups	Other
286 (53.9%)	88 (16.6%)	73 (13.7%)	5 (0.9%)	4 (0.8%)

*missing data = 76

An ANOVA test was performed to compare the difference in mean scores on the key indices, of social work practitioners who work with more of one type of client/patient system than another (Table 8), and no significant differences were found.

Years of Practice (Item #4):

In terms of years of practice, the mean was 16.02 years (S.D. = 9.07 years). A bi-variate correlation was performed and found significant only for the variable of use with years of practice. There was a slight positive correlation between years of practice and use ($r = .09$, $p = .034$), suggesting that the more years of practice that a practitioner had, the more likely he/she would be to use the psychoanalytic model, and the concepts of transference and countertransference.

Current Employment Setting (Item #5a):

The largest number of respondents currently work in private practice, with the second largest group represented working within a hospital setting – mental health unit. (Table 9).

Table 9

Current Employment Setting (Item #5a) (n = 470)

Employment Setting	n	%
Private Practice	115	24.5
Hospital – Mental Health	100	21.3
Family Service Agency	57	12.1
Hospital – Medical	53	11.3
Social Agency setting	48	10.2
Academic/Teaching	14	3.0
School setting	14	3.0
Organizational setting	3	0.6
Correctional setting	2	0.4
Other	64	13.6

*missing data = 62

ANOVA tests were performed to compare social work practitioners' current employment settings (Table 9) with their mean scores on the key indices; all tests were not significant.

Previous Employment Setting (Item #5b):

ANOVA tests were performed to investigate possible relationships between social work practitioners' previous employment settings with their mean scores on the key indices. Significant

differences in means were found for the variables of attitude where $F(9, 388) = 2.28$, $p = .017$ (Table 10), understanding where $F(9, 388) = 3.07$, $p = .001$ (Table 11), and the overall index where $F(9, 388) = 2.96$, $p = .002$ (Table 12).

It is noteworthy that an LSD test found social work practitioners whose previous employment setting (Item #5b) was an academic/teaching one to be significant. These practitioners had a significantly higher mean score for attitude than respondents in any other type of employment setting. (Table 10). Depending on which of the other previous employment settings with which the academic one is being compared, the mean difference ranges from 1.5 - 2.1 on attitude, $p < .05$

Table 10

LSD Test Comparing Mean Differences of Previous Employment Settings Based on Scoring on **the Index of Attitude toward Transference and Countertransference**

Higher Scoring	mean	Lower Scoring	mean	Mean Difference	p
Academic/Teaching	8.75	Private Practice	7.13	1.62	.023
Academic/Teaching	8.75	Social Agency setting	6.61	2.14	.001
Academic/Teaching	8.75	Family Service agency	6.73	2.02	.001
Academic/Teaching	8.75	Hospital-Mental Health	7.00	1.75	.004
Academic/Teaching	8.75	Hospital-Medical	6.94	1.81	.004
Academic/Teaching	8.75	Correctional setting	6.64	2.11	.004
Academic/Teaching	8.75	School setting	7.19	1.56	.035

Using the LSD test, on understanding, when private practice is compared to several other employment settings, those social work practitioners who previously worked in private practice scored highest on this index. (Table 11). Also, when Hospital-Mental Health setting is compared with several other settings, those practitioners who worked in Hospital-Mental Health scored higher. (Table 11).

Table 11

LSD Test Comparing Mean Differences of Previous Employment Settings Based on Scoring on **the Index of Understanding of Transference and Countertransference**

Higher Scoring	mean	Lower Scoring	mean	Mean Difference	p
Private Practice	5.87	Family Service agency	4.66	1.21	.015
Private Practice	5.87	Hospital-Medical	4.79	1.08	.034
Private Practice	5.87	School setting	4.10	1.78	.007
Hospital-Mental Health	5.63	Family Service agency	4.66	0.97	.002
Hospital-Mental Health	5.63	Hospital-Medical	4.79	0.84	.013
Hospital-Mental Health	5.63	School setting	4.10	1.54	.004

Using the LSD test, on the overall index, when private practice is compared to several other employment settings, those social work practitioners who previously worked in private practice scored highest on this index. (Table 12). Also, when Hospital-Mental Health setting is compared with other types of settings, those practitioners who worked in Hospital-Mental Health scored higher. (Table 12).

Table 12

LSD Test Comparing Mean Differences of Previous Employment Settings Based on Scoring on **the Overall Index of Transference and Countertransference**

Higher Scoring	mean	Lower Scoring	mean	Mean Difference	p
Private Practice	6.47	Family Service agency	5.72	0.75	.023
Private Practice	6.47	Hospital-Medical	5.67	0.80	.019
Private Practice	6.47	Social Agency setting	5.79	0.68	.003
Private Practice	6.47	Correctional setting	5.59	0.88	.041
Hospital-Mental Health	6.29	Family Service agency	5.72	0.57	.007
Hospital-Mental Health	6.29	Social Agency setting	5.79	0.50	.009
Hospital-Mental Health	6.29	Correctional setting	5.59	0.70	.045
Hospital-Mental Health	6.29	Hospital-Medical	5.67	0.62	.006

Majority of Client Systems Currently Being Treated (Item #6a):

In terms of their clinical practice, among the social workers who responded to this item (n = 531) the majority of respondents chose "individuals" to describe the majority of client/patient systems they currently treat, and the second largest number of respondents chose "couples". (Table 13).

Table 13

Current Client/Patient Systems (Item #6a) (n = 531)

Individuals	Couples	Families	Groups	Other
347 (65.3%)	97 (18.3%)	74 (13.9%)	10 (1.9%)	3 (0.6%)

An ANOVA test was performed to compare the mean scores of social work practitioners who work with different client systems (Table 13); all tests were not significant.

Number of Couples Treated (Item #6b):

The mean number of couples currently treated per year, by respondents in this sample is 24.06 couples (S.D. = 42.15). A slight negative correlation was found between the number of couples treated (Item #6b) and the acknowledgment score ($r = -.10$, $p = .02$), suggesting that the more a practitioner treated couples, the less likely he/she were to acknowledge transference and countertransference. On further investigation, it was discovered that this was only the case for respondents who saw/treated very large numbers of couples. (When respondents who saw 100 or more couples were removed from the sample, there were no significant correlations.)

Frequency with which Couples are Being Counselled (Item #7a):

In terms of the frequency with which social work clinicians counsel couples, the largest number of respondents/clinicians treat couples on a weekly basis, with the next largest number of respondents/clinicians treating couples once every two weeks. (See Table 14).

Table 14

Frequency with which Clinicians Counsel Couples (Item #7a) (n = 522)

Frequency	n	%
Once per week	143	27.4
Once every 2 weeks	134	25.7
Once every 5 - 16 weeks	85	16.3
Two or more times a week	76	14.6
Once every 4 weeks	54	10.3
Once every 3 weeks	28	5.4
Never	2	0.4

*missing data = 10

A positive correlation was found between the frequency with which practitioners counsel couples (Item #7a) and the score on use ($r = .10$, $p = .019$), suggesting that the more frequently a practitioner sees/treats couples, the more likely he/she is to use psychoanalytic theory, and the concepts of transference and countertransference.

Type of Treatment Format (Item #7b):

In terms of treatment format, the majority of respondents treat couples in conjoint sessions (as a couple together), with the second largest number of respondents treating the couple system through an equal combination of individual and conjoint counselling sessions. A small number of respondents who treat couples see partners/mates individually. (Table 15)

Table 15

Treatment Format (Item #7b) (n = 518)

Format	n	%
Conjoint sessions	304	58.7
Equal combinations of individual and conjoint sessions	183	35.3
Individual sessions	31	6.0

*missing data = 14

The (greater the) use of conjoint sessions (i.e. as a couple together) as a treatment format proved to be positively correlated to: the score on awareness ($r = .126$, $p = .004$), score on

acknowledgment (r = .090, p = 042), score on understanding (r = .097, p = .028), score on overall index (r = .133, p = .002) and score on use (r = .111, p = .011), suggesting that those who see couples conjointly are likely to score higher on these measures. These respondents are more likely to be aware of and acknowledge transference and countertransference, and understand these concepts, as well as perform well on the overall index. Additionally, these respondents would also be more likely to use the psychoanalytic model, and the concepts of transference and countertransference in their clinical practice with couples.

Length of Treatment (in Number of Sessions) (Item #7c):

As outlined in Table 16, the majority of respondents treat couples in 1 - 10 sessions, which this researcher has classified as Brief Therapy, the second largest number of respondents treat couples in 11 - 20 sessions, and a very small number of respondents (4.6%) treat couples in 21 or more sessions, which this researcher has classified as Long-Term or more intensive therapy. Of interest to note is that 5.0% respondents selected "Not Sure" to indicate how many sessions they would generally use to treat couples.

Table 16

Length of Treatment – in Number of Sessions (Item #7c) (n = 525)

Number of Sessions	n	%
1 – 10 sessions	380	72.4
11 – 20 sessions	95	18.1
21 or more sessions	24	4.6
Not Sure	26	5.0

*missing data = 7

The type of treatment as defined by length of treatment (in number of sessions) proved to be positively correlated to acknowledgment (r = .211, p = .001), attitude (r = .144, p = .001), overall index (r = .204, p = .001) and use (r = .341, p = .001), suggesting that those who see/treat couples for a longer period over time are more likely to acknowledge and have a positive attitude toward

psychoanalytic approaches, and the concepts of transference and countertransference, and to use them.

Clinical Supervision (Items #8a and #8b):

In terms of clinical supervision (Item #8a), less than half of all respondents have a clinical supervisor as indicated by "Yes"; the majority of respondents do not. (Table 17). Of the respondents who have a clinical supervisor, the largest group receives 2 – 3 hours of supervision per month, and the second largest group of respondents receive 1 hour per month. (See Table 18).

A t-test was performed and demonstrated that there was no significant difference between the mean scores of practitioners who had clinical supervision and practitioners who did not. (Table 17).

Table 17

Clinical Supervision (Item #8a) (n = 529)

Supervision	n	%
Yes	227	42.9
No	302	57.1

*missing data = 3

Table 18

Hours of Clinical Supervision per Month (Item #8b) (n = 223)

Hours of Supervision	n	%
2 – 3 hours	80	35.9
1 hour	75	33.6
4 – 5 hours	33	14.8
0 hours	15	6.7
6 or more hours	8	3.6
Other	12	5.4

*missing data = 309

There was no significant correlation found between the number of hours of clinical supervision received (Item #8b) and how practitioners scored on the key indices.

Peer Supervision (Item #8c):

Among these respondents who are social workers, the majority of respondents receive peer

supervision/consultation; less than half of the respondents do not receive peer supervision. (See Table 19). Of those respondents who received peer supervision, the mean was 3.41 hours with a Standard Deviation of 2.70.

Table 19

Peer Supervision (Item #8c) (n =529)

Supervision	n	%
Yes	386	73.0
No	143	27.0

*missing data = 3

A t-test demonstrated that there was a significant difference between those social work practitioners who received peer supervision (and those who did not) (See Table 19), on scoring on the overall index. Practitioners who received peer supervision scored higher on the overall index than those who did not receive peer supervision. The mean difference was .31, $t(527) = 2.48$, $p = .013$.

A positive correlation was found between the number of hours of peer supervision received and the scoring on acknowledgment ($r = .138$, $p = .009$). This suggests that those respondents who had a greater number of hours of peer supervision were more likely to acknowledge transference and countertransference.

Theoretical Orientation - as related to couples in general (Item #9a):

Regarding the type of theoretical model found to be most useful in working with couples, among the respondents who answered this question (n = 505), the largest group of respondents chose "Cognitive Behavioural" as their first choice. (See Table 20). The next model of choice was "Eclectic", being chosen by the second largest number of respondents. The third most popular response was "Systems", and the next most popular choice was the "Communication" model. Only a small number of respondents (29 = 5.7%) chose the "psychoanalytic" model. The psychoanalytic model was one of the least popular models, in terms of respondents' first choice. It

is interesting to note that although more respondents (88 = 17.4%) gave the Psychoanalytic model *consideration* as a useful model when working with couples, as indicated when they selected this model as *one of their top three choices,* nevertheless this was a small number of respondents.

Table 20

Theoretical Orientation (Item #9a) (n = 505)

Theoretical Model	**n**	**%**
Cognitive Behavioural	96	19.0
Eclectic	76	15.0
Systems	71	14.1
Communication	64	12.7
Emotionally Focused	53	10.5
Psychoanalytic	29	5.7
Insight-Oriented	24	4.8
Cognitive	24	4.8
Behaviour	13	2.6
Social Learning	3	0.6
Role	3	0.6
Ecological	3	0.6
Not Sure	8	1.6
Other	38	7.5

*missing data = 2

An ANOVA test was performed to determine if mean differences in scoring on the key indices are found when social work practitioners with different theoretical orientations were considered. As would be expected, the following key indices proved to be significant on theoretical orientation: acknowledgment where $F(13, 491) = 2.30$ (Table 21) , $p = .006$, attitude where $F(13, 491) = 5.52$, $p = .001$ (Table 22), overall index where $F(13, 491) = 4.29$, $p = .001$ (Table 23), and use where $F(13, 491) = 39.82$, $p = .001$ (Table 24). On acknowledgment, respondents who were psychoanalytically oriented scored higher than all of the other practitioners with different theoretical orientations. (Table 21).

Table 21

LSD Test Comparing Mean Differences of Theoretical Orientation Based on Scoring on **the Index of Acknowledgment of Transference and Countertransference**

Higher Scoring	mean	Lower Scoring	mean	Mean Difference	p
Psychoanalytic	7.99	Cognitive Behavioural	5.99	1.20	.001
Psychoanalytic	7.99	Eclectic	5.91	2.08	.001
Psychoanalytic	7.99	Systems	6.24	1.74	.002
Psychoanalytic	7.99	Communication	6.28	1.71	.002
Psychoanalytic	7.99	Emotionally Focused	6.05	1.94	.001
Psychoanalytic	7.99	Behavioural	4.36	3.63	.001

Of interest to note is that respondents with the Behavioural orientation scored the lowest on acknowledgment, of all of the orientations. (Table 21).

On attitude, respondents who were psychoanalytically oriented scored higher than all of the other practitioners with different theoretical orientations. (Table 22)

Table 22

LSD Test Comparing Mean Differences of Theoretical Orientation Based on Scoring on **the Index of Attitude toward Transference and Countertransference**

Higher Scoring	mean	Lower Scoring	mean	Mean Difference	p
Psychoanalytic	8.56	Cognitive Behavioural	6.71	1.86	.001
Psychoanalytic	8.56	Eclectic	7.06	1.50	.001
Psychoanalytic	8.56	Systems	7.04	1.53	.001
Psychoanalytic	8.56	Communication	6.97	1.59	.001
Psychoanalytic	8.56	Emotionally Focused	7.08	1.49	.001
Psychoanalytic	8.56	Behavioural	4.42	4.14	.001
Psychoanalytic	8.56	Insight-Oriented	5.90	2.66	.001

Of interest to note is that respondents with the Behavioural orientation scored the lowest on attitude, of all of the orientations. Also of interest is that the Insight-Oriented respondents (n = 24) had a mean difference that was second lowest (2.66, p = .001). (Table 22).

On the overall index, respondents who were psychoanalytically oriented scored higher than all of the other practitioners with different theoretical orientations. (Table 23).

Table 23

LSD Test Comparing Mean Differences of Theoretical Orientation Based on Scoring on **the Overall Index of Transference and Countertransference**

Higher Scoring	mean	Lower Scoring	mean	Mean Difference	p
Psychoanalytic	7.17	Cognitive Behavioural	5.81	1.36	.001
Psychoanalytic	7.17	Eclectic	5.87	1.30	.001
Psychoanalytic	7.17	Systems	5.98	1.18	.001
Psychoanalytic	7.17	Communication	6.11	1.06	.001
Psychoanalytic	7.17	Emotionally Focused	6.15	1.01	.001
Psychoanalytic	7.17	Behavioural	4.35	2.81	.001

Of interest to note is that respondents with the Behavioural orientation scored the lowest on the overall index, of all of the orientations. (Table 23).

On use, respondents who were psychoanalytically oriented scored higher than all of the other practitioners with different theoretical orientations. (Table 24).

Table 24

LSD Test Comparing Mean Differences of Theoretical Orientation Based on Scoring on **the Index of Use of the Psychoanalytic Model, and of Transference and Countertransference**

Higher Scoring	mean	Lower Scoring	mean	Mean Difference	p
Psychoanalytic	4.94	Cognitive Behavioural	1.10	3.84	.001
Psychoanalytic	4.94	Eclectic	1.41	3.54	.001
Psychoanalytic	4.94	Systems	1.27	3.67	.001
Psychoanalytic	4.94	Communication	1.23	3.71	.001
Psychoanalytic	4.94	Emotionally Focused	1.54	3.40	.001
Psychoanalytic	4.94	Behavioural	1.00	3.94	.001
Emotionally Focused	1.54	Cognitive Behavioural	1.10	0.44	.003
Eclectic	1.41	Cognitive Behavioural	1.10	0.31	.020

Of interest to note is that respondents with the Behavioural orientation scored the lowest on use, of all of the respondents with other theoretical orientations. (Table 24).

Table 25

Scores on the Key Indices by Theoretical Orientation: Social Workers who Treat Couples (Six largest groups)

Theoretical Orientation	n	Awareness Score	Acknow-ledgment Score	Under-standing Score	Attitude Score	Overall Index Score	Use Score
Cognitive Behavioural	96	5.13 S.D.= 1.59	5.99 S.D. = 2.29	5.40 S.D. = 1.94	6.71 S.D. = 1.75	5.81 S.D. = 1.14	1.10 S.D.=.75
Eclectic	76	5.61 S.D. =1.55	5.91 S.D. = 2.69	4.89 S.D. = 1.88	7.06 S.D. = 1.96	5.87 S.D. = 1.29	1.41 S.D.=.87
Systems	71	5.33 S.D. = 1.57	6.24 S.D. = 2.30	5.31 S.D. = 2.05	7.04 S.D. = 1.65	5.98 S.D. = 1.25	1.27 S.D.=.97
Communi-cation	64	5.74 S.D. = 1.87	6.28 S.D. = 2.70	5.45 S.D. = 1.82	6.97 S.D. = 1.41	6.11 S.D. = 1.21	1.23 S.D.=.65
Emotionally Focused	53	5.96 S.D. = 1.45	6.05 S.D. = 2.83	5.53 S.D. = 1.98	7.06 S.D. = 1.71	6.15 S.D. = 1.24	1.54 S.D.=.95
Psycho-analytic	29	6.34 S.D. = 1.72	7.99 S.D. = 2.40	5.76 S.D. = 1.24	8.56 S.D. = 1.25	7.17 S.D. = 1.01	4.94 S.D.=1.39

Of all respondents in this sample, those who identified themselves as psychoanalytically oriented attained better scores on all of the key indices. (Table 25)

Identification of 3 Main Tenets or Key Concepts of the Psychoanalytic Model (Item #9b):

On this question, where respondents who chose the psychoanalytic model as their Most Useful theoretical model (in #9a), were asked to identify 3 main tenets or key concepts for this model, there were 29 respondents who selected this model. Out of a possible 87 opportunities (3 main tenets x 29 respondents) for these respondents to identify main tenets of the psychoanalytic model, there was a total of 70 (80.5%) correctly identified main tenets or key concepts made that characterize this (psychoanalytic) model, with 26 of the respondents identifying at least one correct tenet. There were 3 respondents who claimed to be psychoanalytically oriented and could not identify even one tenet of this model.

Theoretical Orientation - as related to the couple in the vignette (Item #11a):

Respondents were asked to choose the Most Useful model for treating the couple in the

vignette. Of the respondents who answered this question (n = 512), only 33 (6.4%) selected the psychoanalytic model as their *first choice*, and 93 (18.2%) selected the psychoanalytic model as *one of their top three* choices.

Identification of Transference and Countertransference as Key Issues for the Vignette Couple (Item #11b):

On this item, where respondents were asked to identify three key issues in terms of what is going on with the vignette couple, there were 522 respondents who responded on this item. Out of a possible 1,566 opportunities (3 possible answers x 522 respondents on this item) for these respondents to identify transference and/or countertransference, only 50 (3.2%) accurate identifications of these concepts were made. In general, the majority of respondents did not make even one accurate identification of transference or countertransference as key issues for the vignette couple.

While the general sample of social workers who treat couples made 3.2% accurate identifications of transference and countertransference, those who graduated with their M.S.W. degree in the 1960s had 9.0% accurate identifications of these concepts. Those respondents who graduated with their M.S.W. degree in the 1970s had 5.5% accurate identifications of these concepts, and those who graduated in the 1980s had 2.1% accurate identifications of these concepts. This suggests that respondents who graduated with their M.S.W. degree in the 1960s (n = 26) were more able to identify transference and countertransference as key issues. Respondents who graduated with their M.S.W. degree in the 1970s (n = 79) were the next group most able to identify transference and countertransference as key issues.

Scoring on the Key Indices – Where the Theoretical Meets the Clinical Application:

In terms of scoring on the questionnaire, the mean scores on the key indices attained by this group of social work practitioners who treat couples is outlined in Table 26.

Table 26

Mean Scoring on the Key Indices

	Awareness	Acknowledgment	Understanding	Attitude	Overall Index	Use
Score	5.52	6.17	5.52	6.93	5.96	1.50
S.D.	1.70	2.53	1.70	1.79	1.27	1.24

Overall, this sample of social work practitioners scored "Average" in terms of their awareness and understanding, relatively "Average-High" on acknowledgment and attitude, and "Average" on the overall index. This group's score was rated (very) "Low" on use which is their demonstrated application of transference and countertransference (on the vignette).

3. <u>Other Therapists who do Couples Counselling</u>:

As displayed in Figure 1, the total number of other therapists who treat couples is 122 or 18.7% of the primary sample. As in the previous section, the relationship between variables and the key indices are reported here.

<u>Gender (Item #1) and the Key Indices:</u>

This sample of respondents who are therapists who treat couples is comprised of a majority of female respondents. (See Table 27).

Table 27

Gender (Item #1) (n = 122)

Male	Female
44 (36.1%)	78 (63.9%)

*missing data = 0

There were no gender differences on the scoring of the key indices (See Table 27); all t-tests were not significant.

<u>Education (Item #2) and the Key Indices:</u>

Table 28 illustrates the breakdown of educational degrees for this subsample of other therapists

who treat couples. Of these 122 other therapists, the majority of respondents have an M.A. degree in a counselling-related discipline, the largest number of whom have an M.A. in Pastoral Counselling/Theology/Divinity (41 = 33.6% of this group).

Table 28

Education (Item #2) (n = 122)

Degree	n	%
M.A. in Pastoral Counselling/Divinity/Theology	41	33.6
M.A. in Psychology	9	7.4
M.A. in Marriage, Family and Child Counselling	9	7.4
M.A. in Counselling-related discipline	43	35.2
Other Degrees	20	16.4

*missing data = 0

Included in the above table were practitioners who also had the following degrees:
2 Psychology-related certificate
1 Psychoanalytic certificate/training
21 OAMFT/AAMFT clinical members/supervisors
1 Ph.D. in social work
5 Ph.D. in psychology
2 Ph.D. in pastoral counselling
5 Ph.D. in other fields

It is interesting to note that "other" degrees/certificates held by these therapists and included are: 13 Ph.D.s (the largest group is in Psychology and numbers 5), and other degrees/diplomas among which belong to the category of OAMFT/AAMFT clinical member/approved supervisor and number 21. Some of these "other" degrees/certificates were in addition to holding an M.A. degree. T-tests were performed and no significant differences were found on the key indices for practitioners who had an M.A. in counselling in comparison with those who did not. (Table 28).

Present and Previous Professional/Employment Experience (Item #3b):

All respondents (n = 122) indicated "presently working as a clinical social worker/therapist/ counsellor" as their response on this item, and the majority had previously worked in this capacity (See Table 29).

Table 29

Previously Employed as a Clinical Social Worker/Therapist/Counsellor (Item #3b) (n = 114)

Previously employed	Not previously employed
102 (89.5%)	12 (10.5%)

*missing data = 8

A t-test was performed to compare mean scores of practitioners who had previous professional employment as a therapist with those who did not. Significant differences were found for the variable of use. Practitioners with previous professional employment scored significantly higher on the index of use. The mean difference was .68, $t(47.0) = 3.34$, $p = .002$. (Table 29). This finding suggests that practitioners with previous professional employment as a clinical social worker/therapist/counsellor were more likely to use the psychoanalytic model, and transference and countertransference in their work with couples.

Majority of Client Systems Treated in Previous Professional/Employment Experience (Item #3c):

The majority of client/patient systems treated by the respondents in the past, as indicated by the largest number of respondents in the subsample, was "individuals". (Table 30).

Table 30

Previous Client/Patient Systems (Item #3c) (n = 92)

Individuals	Couples	Families	Groups	Other
51 (41.8%)	29 (23.8%)	9 (7.4%)	1 (0.8%)	2 (1.6%)

*missing data = 30

An ANOVA test was performed to determine whether or not the majority of client/patient systems treated in previous clinical experience (Table 30) impacted upon scoring on any of the key indices. Results of the test were not significant.

Years of Practice (Item #4):

In terms of years of practice, the mean was 12.23 years. (S.D. = 8.35 years). A bi-variate correlation was run and found to not be significant for scoring on any of the key indices (i.e.

awareness, acknowledgment, etc.) with years of practice.

Current Employment Setting (Item #5a):

The majority of respondents currently work in private practice, with the second largest group of respondents working within a family service agency. (See Table 31 for further details.)

Table 31

Employment Setting (Item #5a) (n = 107)

Employment Setting	n	%
Private Practice	58	54.2
Family Service agency	14	13.1
Social Agency setting	12	11.2
Academic/Teaching	4	3.7
Other	19	17.8

*missing data = 15

ANOVA tests were performed to investigate whether therapists' current employment settings (Item #5a) were associated with the differences on their mean scores on the key indices. Significant differences were found for the acknowledgment index where $F(7, 99) = 2.22$, $p = .039$ (Table 31), and the attitude index where $F(7, 99) = 2.20$, $p = .04$ (Table 31). Therapists whose present employment setting was an academic/teaching one proved to be significantly different on the acknowledgment index score. On acknowledgment, when academic/teaching is compared with hospital-medical setting, the mean difference is 4.58, $p = .034$. Therapists whose present employment setting is an academic/teaching one had a significantly higher mean score for acknowledgment than respondents who work in a hospital-medical setting.

On the attitude index, when private practice was compared to social agency setting, the mean difference is 1.60, $p = .024$ Therapists whose present employment setting is private practice scored higher on attitude than those who work in a social agency setting.

Previous Employment Setting (Item #5b):

ANOVA tests were performed to investigate a possible relationship between therapists' previous employment settings, and the differences on their mean scores for the various indices. Significant differences were found for the acknowledgment index where $F(9, 81) = 2.10$, $p = .039$ (Table 32), understanding index where $F(9, 81) = 2.49$, $p = .014$ (Table 33), and the overall index where $F(9, 81) = 2.24$, $p = .028$ (Table 34).

Table 32

LSD Test Comparing Mean Differences of Previous Employment Settings Based on Scoring on **the Index of Acknowledgment of Transference and Countertransference**

Higher Scoring	Mean	Lower Scoring	mean	Mean Difference	p
Private Practice	6.99	Hospital-Medical	4.17	2.82	.014
Private Practice	6.99	Correctional setting	0.83	6.15	.001
Social agency	6.44	Hospital-Medical	4.17	2.28	.029
Social agency	6.44	Correctional setting	0.83	5.61	.002
Family service	6.08	Correctional setting	0.83	5.25	.004
Hospital-Mental health	6.94	Correctional setting	0.83	6.11	.003
Academic/Teaching	6.00	Correctional setting	0.83	5.17	.012

As illustrated in Table 32, in general, respondents whose previous employment setting was private practice scored higher on the index of acknowledgment than respondents in many of the other employment settings. An interesting finding was that those respondents who work in correctional settings scored the lowest on this index.

Table 33

LSD Test Comparing Mean Differences of Previous Employment Settings Based on Scoring on **the Index of Understanding of Transference and Countertransference**

Higher Scoring	Mean	Lower Scoring	mean	Mean Difference	p
Private Practice	6.15	Family Service agency	4.57	1.58	.009
Private Practice	6.15	Academic/Teaching	4.29	1.87	.036
Social agency	5.60	Family Service agency	4.57	1.03	.040
Hospital-Medical	6.33	Family Service agency	4.57	1.76	.019
Hospital-Medical	6.33	Academic/Teaching	4.29	2.04	.039
Correctional setting	7.14	Family Service agency	4.57	2.57	.040
Correctional setting	7.14	Academic/Teaching	4.29	2.86	.044

As illustrated in Table 33, in general, respondents whose previous employment setting was private practice scored higher on the index of understanding than those respondents previously employed in family service agency settings, or those respondents whose previous work setting had been an academic/teaching one. Of interest is that respondents whose previous employment had been either hospital-medical or correctional settings who are typically the lowest scoring groups on the other key indices, scored highest on this index of understanding (when compared with those respondents whose previous employment was in any other type of setting, except for private practice).

Table 34

LSD Test Comparing Mean Differences of Previous Employment Settings Based on Scoring on **the Overall Index of Transference and Countertransference**

Higher Scoring	Mean	Lower Scoring	mean	Mean Difference	p
Private Practice	6.87	Family Service agency	5.78	1.10	.022
Private Practice	6.87	Hospital-Medical	5.58	1.29	.040
Private Practice	6.87	Correctional setting	4.66	2.21	.030
Private Practice	6.87	Academic/Teaching	5.16	1.71	.016
Hospital-Mental Health	7.02	Family Service agency	5.78	1.24	.046
Hospital-Mental Health	7.02	Correctional setting	4.66	2.35	.032
Hospital-Mental Health	7.02	Academic/Teaching	5.16	1.85	.023

Table 34 outlines significant comparisons of mean differences of previous employment settings based on scoring on the overall index. Respondents who had previously worked in private practice scored higher on the overall index than those previously employed in family service agency settings, those in hospital-medical settings, in correctional settings, and academic/teaching settings. An interesting finding was that respondents in hospital-mental health settings scored higher than those in family service agency settings, those in correctional settings, and those in academic/teaching settings.

Majority of Client Systems Currently Being Treated (Item #6a):

In terms of clinical practice, the majority of respondents chose "individuals" to describe the

majority of clients/patient systems whom they currently treat, and the second largest number of respondents chose "couples". (See Table 35 for further details.)

Table 35

Current Client/Patient Systems (Item #6a) (n = 122)

Individuals	Couples	Families	Groups	Other
63 (51.6%)	49 (40.2%)	8 (6.6%)	1 (0.8%)	1 (0.8%)

*missing data = 0

ANOVA tests were performed to investigate a possible relationship between therapists who work with different client systems (Item #6a), and the differences on their mean scores on the key indices. Significant differences in mean scores were found for the index of acknowledgment where $F(2, 117) = 3.87$, $p = .024$ (Table 35). Therapists who currently treat individuals as the majority of their clients/patient systems had a mean score on acknowledgment of 6.35, S.D = 2.43; therapists who currently treat couples as the majority of their clients/patient systems had a mean score of 5.09, S.D. = 2.59. Therapists who currently treat individuals as the majority of their clients/patient systems scored significantly higher on acknowledgment than those who treat couples. The difference in mean scores was 1.26, $p = .008$

Number of Couples Treated (Item #6b):

The mean number of couples currently treated per year by respondents in this sample is 28.74 couples (S.D. = 39.87).

A slight negative correlation was found between the number of couples treated (Item #6b) and the attitude index ($r = -.179$, $p = .048$). Another slight negative correlation was found between the number of couples treated and the overall index ($r = -.178$, $p = .049$). This suggests that the more couples a practitioner treats, the less likely he/she is to have a positive attitude toward transference and countertransference. On further investigation, it was discovered that this was only the case for respondents who treated very large numbers of couples. (When respondents who treated 100 or more couples were removed from the sample, there were no significant correlations.)

Frequency with which Couples are Being Counselled (Item #7a):

In terms of the frequency with which clinicians in this sample counsel couples, the largest number of respondents/clinicians treat couples on a weekly basis, with the second largest number of respondents/clinicians treating couples once every two weeks. (See Table 36 for further details.) A bi-variate correlation was run, investigating whether the frequency with which these other therapists counsel couples (Item #7a) is associated with the scores on the key indices; this was done through comparing the frequency with which therapists counsel couples and the scores on the key indices. No significant relationship was found.

Table 36

Frequency with which Clinicians Counsel Couples (Item #7a) (n = 120)

Frequency	n	%
Once per week	42	35.0
Once every 2 weeks	31	25.8
Two or more times a week	29	24.2
Once every 5 - 16 weeks	9	7.5
Once every 4 weeks	6	5.0
Once every 3 weeks	2	1.7
Never	1	0.8

*missing data = 2

Table 37

Treatment Format (Item #7b) (n = 121)

Format	n	%
Conjoint sessions	94	77.7
Equal combinations of individual and conjoint sessions	25	20.7
Individual sessions	2	1.7

*missing data = 1

Type of Treatment Format (Item #7b):

In terms of treatment format, the majority of respondents treat couples in conjoint sessions (as a couple together), with less than one third of respondents treating the couple system through an equal combination of individual and conjoint counselling sessions. A very small number of respondents (1.7%) who treat couples see partners/mates individually. (Table 37). A bi-variate correlation was run, investigating the relationship between the type of treatment format (Item #7b) and the scores on the key indices; this was done by comparing the type of treatment format and the scores on the key indices. No significant association was found.

Length of Treatment (in Number of Sessions) (Item #7c):

The majority of respondents treat clients in 1 – 10 sessions, which this researcher has classified as Brief Therapy, and the second largest number of respondents treat clients in 11 – 20 sessions. A small number of respondents (3.4%) treat clients in 21 or more sessions, which this researcher has classified as Long-Term or more intensive therapy. (Table 38).

Table 38

Length of Treatment – in Number of Sessions (Item #7c) (n = 118)

Number of Sessions	n	%
1 – 10 sessions	82	69.5
11 – 20 sessions	27	22.9
21 or more sessions	4	3.4
Not Sure	5	4.2

*missing data = 4

As might be expected, length of treatment (in number of sessions) was positively correlated to the index of use ($r = .244$, $p = .009$). This suggests that the longer the treatment that a practitioner employs in treating couples, the more likely he/she is to use the psychoanalytic model, and transference and countertransference in working with couples.

Clinical Supervision (Items #8a and #8b):

In terms of clinical supervision, the majority of respondents have a clinical supervisor; a little less than half of all respondents do not. (See Table 39). Of the respondents who have a clinical supervisor, the largest group receives 2 - 3 hours of supervision per month, and the second largest number of respondents receives 4 - 5 hours per month. (See Table 40 for further details.)

Table 39

Clinical Supervision (Item #8a) (n = 121)

Supervision	n	%
Yes	64	52.9
No	57	47.1

*missing data = 1

Table 40

Hours of Clinical Supervision per Month (Item #8b) (n = 63)

Hours of Supervision	n	%
2 – 3 hours	21	33.3
1 hour	13	20.6
4 – 5 hours	17	27.0
0 hours	3	4.8
6 or more hours	8	12.7
Other	1	0.8

*missing data = 59

Table 41

Peer Supervision (Item #8c) (n =121)

Supervision	n	%
Yes	88	72.7
No	33	27.3

*missing data = 1

T-tests were performed and demonstrated that there was a slight difference between the mean scores of therapists who had clinical supervision and therapists who did not (Table 39), on understanding. Therapists who did not receive clinical supervision had a higher mean score on understanding (mean = 5.46, S.D. = 1.81) than therapists who received clinical supervision (mean = 4.73, S.D. = 1.82). The mean difference in scores was .732, $t(119) = 2.21$, $p = .029$. There was no significant relationship found between the number of hours of clinical supervision (Item #8b) and how therapists scored on the key indices.

Peer Supervision (Item #8c):

The majority of respondents receive peer supervision/consultation; 33 (27.3%) do not. (Table 42). Of those respondents who receive peer supervision, the mean was 3.46 hours with a Standard Deviation of 2.55.

A t-test was performed to compare therapists who received peer supervision with those who had not (Table 41), on the six key indices. None was significant.

A bi-variate correlation was run to determine if there was an association between the number of hours of peer supervision received and the scoring on the six key indices, and none were significant.

Theoretical Orientation – as related to couples in general (Item #9a):

Regarding the type of theoretical model found to be most useful in working with couples, among the respondents who answered this question, the largest group of respondents chose "Systems" as their *first* choice. The next model of choice was "Eclectic", being chosen by the second largest number of respondents. The third most popular response was "Emotionally Focused", which was selected by a small number of respondents; an even smaller number of respondents (9 = 7.8%) chose the psychoanalytic model. (See Table 42 for further details.)

It is interesting to note that 21 (18.1%) respondents *considered* the psychoanalytic model as a useful model when working with couples, as indicated when they selected this model as *one of their top three choices,* although this same number did not select it as their *first* model of choice.

Table 42

Theoretical Orientation (Item #9a) (n = 116)

Theoretical Model	n	%
Systems	37	31.9
Eclectic	22	19.0
Emotionally Focused	16	13.8
Communication	9	7.8
Cognitive Behavioural	9	7.8
Psychoanalytic	9	7.8
Insight-Oriented	2	1.7
Cognitive	1	0.9
Behaviour	1	0.9
Social Learning	1	0.9
Not Sure	1	0.9
Other	8	6.9

*missing data = 6

An ANOVA test was performed to investigate mean differences in scoring on the key indices by therapists with different theoretical orientations. The ANOVA was significant where $F(7, 104) = 49.63$, $p = .001$ only on the index of use/practical application. (Table 43).

Table 43

LSD Test Comparing Mean Differences of Theoretical Orientation Based on Scoring on **the Index of Use of the Psychoanalytic Model, and of Transference and Countertransference**

Higher Scoring	mean	Lower Scoring	Mean	Mean Difference	p
Psychoanalytic	5.96	Cognitive Behavioural	0.74	5.22	.001
Psychoanalytic	5.96	Eclectic	1.10	4.86	.001
Psychoanalytic	5.96	Systems	1.38	4.58	.001
Psychoanalytic	5.96	Communication	1.31	4.65	.001
Psychoanalytic	5.96	Emotionally Focused	1.86	4.10	.001
Emotionally Focused	1.86	Cognitive Behavioural	0.74	1.12	.003
Emotionally Focused	1.86	Systems	1.38	0.48	.031
Emotionally Focused	1.86	Eclectic	1.10	0.75	.002

Respondents who were psychoanalytically oriented scored higher on the index of use/practical application than all of the other practitioners with different theoretical orientations. (Table 43). Noteworthy is that respondents with an Emotionally-Focused orientation scored second highest on this index compared with all of the other respondents with different theoretical orientations.

Table 44

Scores on the Key Indices by Theoretical Orientation: Other Therapists who Treat Couples
(Six largest groups)

Theoretical Orientation	n	Awareness Score	Acknow-ledgment Score	Under-standing Score	Attitude Score	Overall Index Score	Use Score
Systems	37	6.00 S.D.= 1.76	6.04 S.D. = 2.46	5.52 S.D. = 1.88	6.76 S.D. = 2.14	6.08 S.D. = 1.48	1.38 S.D.=.71
Eclectic	22	5.27 S.D. =1.96	5.64 S.D. = 3.02	4.68 S.D. = 2.03	6.52 S.D. = 2.71	5.53 S.D. = 1.82	1.10 S.D.=.68
Emotionally Focused	16	6.09 S.D. = 1.23	6.20 S.D. = 2.38	5.09 S.D. = 1.47	7.42 S.D. = 1.23	6.20 S.D. = .89	1.86 S.D.=1.06
Communi-cation	9	5.44 S.D. = 1.87	6.02 S.D. = 2.03	5.08 S.D. = .75	6.25 S.D. = 1.95	5.70 S.D. = 1.02	1.31 S.D.=.55
Cognitive Behavioural	9	5.89 S.D. = 1.29	5.37 S.D. = 3.20	5.40 S.D. = 1.72	5.79 S.D. = 1.27	5.61 S.D. = .96	0.74 S.D.=.37
Psycho-analytic	9	6.66 S.D. = 1.93	7.22 S.D. = 2.36	4.92 S.D. = 1.45	8.38 S.D. = 1.40	6.80 S.D. = 1.35	5.96 S.D.=.92

Of all respondents in this sample, in general, those who were psychoanalytically oriented attained better scores on most of the key indices (i.e. every key index except the index of understanding; this is unexpected). (See Table 44).

Identification of 3 Main Tenets or Key Concepts of the Psychoanalytic Model (Item #9b):

Of the 9 respondents who chose the psychoanalytic model as their Most Useful theoretical model (in #9a), there was (in #9b) a total of 24 correctly identified main tenets or key concepts that characterize this (psychoanalytic) model, with all 9 respondents identifying at least one correct tenet.

On this question, where respondents who chose the psychoanalytic model as their Most Useful theoretical model (in #9a), were asked to identify 3 main tenets or key concepts for this model, there were 9 respondents who selected this model. Out of a possible 27 opportunities (3 main tenets x 9 respondents) for these respondents to identify main tenets of the psychoanalytic model, there was a total of 24 (88.9%) correctly identified main tenets or key concepts made that characterize this (psychoanalytic) model, with all 9 of the respondents identifying at least one correct tenet.

Theoretical Orientation – as related to the couple in the vignette (Item #11a):

Respondents were asked to choose the Most Useful model, in terms of a more specific case scenario, by selecting the most useful model for treating the couple in the vignette. Among the respondents who answered this question (n = 118), only a small number (10 = 8.5%) selected the psychoanalytic model as their *first* model of choice, and 20 (16.9%) chose the psychoanalytic model as a *consideration* by indicating it as *one of their top three choices*.

Identification of Transference and Countertransference as Key Issues for the Vignette Couple (Item #11b):

On this question, where respondents were asked to identify three key issues in terms of what is going on with the vignette couple, there were 120 respondents who responded on this item. Out of

a possible 360 opportunities (3 possible answers x 120 respondents on this item) for these respondents to identify transference and/or countertransference, only 17 (4.7%) accurate identifications of these concepts were made. In general, the majority of respondents did not make even one accurate identification of transference or countertransference as key issues for the vignette couple.

Scoring on the Key Indices – Where the Theoretical Meets the Clinical Application:

In terms of scoring on the questionnaire, the mean scores on the key indices attained by this group of practitioners who treat couples are outlined in Table 45.

Table 45

Mean Scoring on the Key Indices

	Awareness	Acknowledgment	Understanding	Attitude	Overall Index	Use
Score	5.75	5.91	5.24	6.67	5.85	1.64
S.D.	1.70	2.57	1.93	2.21	1.45	1.44

Overall, this sample of therapists scored "Average" in terms of their awareness, acknowledgment and understanding, relatively "Average-High" on attitude, and "Average" on the overall index. The score for this group of therapists was rated (very) "Low" on use which is their demonstrated application of transference and countertransference (on the vignette).

4. A Comparison of Social Workers and Other Therapists who Treat Couples:

A comparison of the social workers and the other therapists follows, which includes significant differences demonstrated between these two groups. All of the demographic variables and other variables under consideration will be examined.

The first section, "A Comparison of Four Types of Therapists: Social workers and Other Therapists who Counsel Couples" will examine practitioners with their B.S.W. degree, those with their M.S.W. degree only (i.e. no B.S.W. degree), those with both B.S.W. and M.S.W. degrees,

and other therapists who have non-social work or counselling-related degrees. The second section, "A Comparison between Social Workers and Other Therapists who Treat Couples", examines the two groups, social workers and other therapists.

4.1 A Comparison of Four Types of Therapists: Social Workers and Other Therapists who Treat Couples:

The following is an overview of the comparison of scores for social workers and other therapists who treat couples, on awareness, acknowledgment, understanding, attitude, the overall index and use/practical application. (Table 46).

Table 46

Couples Counsellors Sample: A Comparison of Mean Scores on the Key Indices for Three Types of Social Workers and Other Therapists

	B.S.W. n = 94 (14.4%)	**B.S.W. & M.S.W.** n = 153 (23.4%)	**M.S.W.** n = 285 (43.6%)	**Other Therapists** n = 122 (18.7%)
Awareness	5.07 (S.D. 1.55)	5.36 (S.D. 1.77)	5.75 (S.D. 1.68)	5.75 (S.D. 1.70)
Acknowledgment	5.61 (S.D. 2.30)	6.23 (S.D. 2.59)	6.33 (S.D. 2.59)	5.91 (S.D. 2.57)
Understanding	5.00 (S.D. 1.93)	5.40 (S.D. 1.86)	5.23 (S.D. 1.97)	5.07 (S.D. 1.84)
Attitude	6.59 (S.D. 1.95)	6.78 (S.D. 1.66)	7.12 (S.D. 1.79)	6.67 (S.D. 2.21)
Overall Index	5.57 (S.D. 1.17)	5.94 (S.D. 1.26)	6.11 (S.D. 1.29)	5.85 (S.D. 1.45)
Use/Practical Application	1.16 (S.D. 0.79)	1.32 (S.D. 1.00)	1.64 (S.D. 1.36)	1.64 (S.D. 1.44)

Table 46 presents an overview of mean scores, where respondents with their M.S.W. degree (and no B.S.W. degree) have the highest mean scores on all of the key indices. Other therapists scored as high as social workers with their M.S.W. degree only on the indices of awareness of transference and countertransference, and use/practical application of the psychoanalytic model, transference and countertransference.

Degrees held proved to be significant. An ANOVA test was performed for social workers (including those with a B.S.W. degree, those with an M.S.W. degree only, and those with a B.S.W. and M.S.W. degree) and non-social workers/other therapists, to determine if there are significant

differences on the key indices (i.e. awareness, attitude, etc.). The indices of awareness and attitude, the overall index and the index of use proved to be statistically significant. On the awareness index where $F(3, 650) = 5.11$, $p = .002$ (Table 47); on the attitude index where $F(3, 650) = 2.96$, $p = .032$ (Table 48); on the overall index where $F(3, 650) = 4.38$, $p = .005$ (Table 49), and on the index of use where $F(3, 650) = 5.28$, $p = .001$ (Table 50).

Using the LSD test to compare the four groups, comparisons were made and found to be statistically significant; these are presented in the tables that follow.

Table 47

LSD Test Comparing Mean Differences of Education Based on Scoring on **the Index of Awareness of Transference and Countertransference**

Higher Scoring	mean	Lower Scoring	mean	Mean Difference	p
M.S.W.	5.75	B.S.W.	5.07	.68	.001
Other Therapists	5.75	B.S.W.	5.07	.68	.003
M.S.W.	5.75	B.S.W. & M.S.W.	5.36	.39	.022

On the index of awareness, respondents with their M.S.W. degree (and no B.S.W. degree) scored higher than those with their B.S.W. degree. Respondents who had non-social work degrees scored higher than those with their B.S.W. degree on awareness. Respondents with their M.S.W. degree (and no B.S.W. degree) scored higher than those with both their B.S.W. and M.S.W. degrees. (See Table 47).

Table 48

LSD Test Comparing Mean Differences of Education Based on Scoring on **the Index of Attitude toward Transference and Countertransference**

Higher Scoring	mean	Lower Scoring	mean	Mean Difference	p
M.S.W.	7.12	B.S.W.	6.59	.53	.018
M.S.W.	7.12	Other therapists	6.67	.45	.027

The LSD test found the following differences to also be significant: On the attitude index, respondents with their M.S.W. degree (and no B.S.W. degree) scored higher than those with their B.S.W. degree. Practitioners with their M.S.W. degree (and no B.S.W. degree) scored higher than

other therapists who have non-social work degrees. (Table 48).

Table 49

LSD Test Comparing Mean Differences of Education Based on Scoring on
the Overall Index of Transference and Countertransference

Higher Scoring	mean	Lower Scoring	mean	Mean Difference	p
M.S.W.	6.11	B.S.W.	5.57	.54	.001
B.S.W. & M.S.W.	5.94	B.S.W.	5.57	.37	.029

On the overall index, practitioners with both their B.S.W. and M.S.W. degrees scored higher than those with their B.S.W. degree. Respondents with their M.S.W. degree (and no B.S.W. degree) also scored higher than those with only their B.S.W. degree. (See Table 49).

Table 50

LSD Test Comparing Mean Differences of Education Based on Scoring on
the Index of Use of the Psychoanalytic Model, and of Transference and Countertransference

Higher Scoring	mean	Lower Scoring	mean	Mean Difference	p
M.S.W.	1.64	B.S.W. & M.S.W.	1.32	.33	.009
M.S.W.	1.64	B.S.W.	1.16	.48	.001
Other Therapists	1.64	B.S.W.	1.16	.48	.005
Other Therapists	1.64	B.S.W. & M.S.W.	1.32	.32	.033

On the use/practical application index, respondents with their M.S.W. degree (and no B.S.W. degree) scored higher than those with their B.S.W. degree. Respondents who were other therapists with non-social work degrees scored higher than those practitioners with both their B.S.W. and M.S.W. degrees. Respondents with their M.S.W. degree (and no B.S.W. degree) scored higher than those with both their B.S.W. and M.S.W. degrees. (Table 50).

Summary:

In summary, generally, as observed in Table 46, social workers with an M.S.W. degree (with or without a B.S.W. degree) scored marginally higher than non-social workers on the indices of acknowledgment and attitude, and on the overall index. Other therapists scored higher than social

workers with a B.S.W degree only and those with both a B.S.W. and M.S.W. degree, on indices of awareness and application/use. Other therapists scored as well as social workers with their M.S.W. degree alone (i.e. no B.S.W. degree) on the indices of awareness and application/use, and lower on the indices of acknowledgment, understanding, attitude, and the overall index. The findings are fairly consistent among the key indices (i.e. awareness, acknowledgment, understanding, attitude, the overall index, and use/application) that those respondents with a B.S.W. degree (only) do not perform as well on scoring on the key indices as those respondents who have an M.S.W. degree (and no B.S.W. degree). This same observation can be made regarding respondents who have both their B.S.W. and M.S.W. degrees, who scored higher on all six key indices than respondents with their B.S.W. degree only. Additionally, other therapists scored higher on all six key indices than respondents with their B.S.W. degree only.

While the above-stated comments are based upon observations made from the table outlining the mean scores for social workers and other therapists, differences associated with degrees held were found to be statistically significant only for the indices of awareness and attitude, the overall index, and the index of use.

T-tests were performed, comparing respondents who have M.A. degrees with those who have M.S.W. degrees only (Table 46), in terms of scoring on the key indices. All t-tests were not significant.

4.2 A Comparison between Social Workers (as a Group) and Other Therapists who Treat Couples, on Scoring on the Key Indices:

Table 51 presents an overview of the comparison of scores for all social workers and the other therapists who treat couples, on the key indices (i.e. awareness, acknowledgment, understanding, attitude, the overall index, and use/practical application).

Table 51

Couples Counsellors Sample: A Comparison of Social Workers' and Other Therapists' Mean Scores on the Key Indices

	Social Workers n = 532 (81.3%)	**Other Therapists** n = 122 (18.7%)
Awareness	5.52 (S.D. 1.70)	5.75 (S.D. 1.70)
Acknowledgment	6.17 (S.D. 2.53)	5.91 (S.D. 2.57)
Understanding	5.24 (S.D. 1.93)	5.07 (S.D. 1.84)
Attitude	6.93 (S.D. 1.79)	6.67 (S.D. 2.21)
Overall Index	5.96 (S.D. 1.27)	5.85 (S.D. 1.45)
Use	1.46 (S.D. 1.19)	1.64 (S.D. 1.44)

Although there were observable marginal differences in mean scores between the two groups (i.e. social workers and other therapists) on the key indices (See Table 51), when t-tests were performed, comparing the mean scores attained by social workers and other therapists, they were not significant for any of the key indices.

4.3 Demographic Differences:

In terms of the demographic factors, the following brief overview and summary outline the differences between all social work practitioners and the other therapists. The demographic variables that were examined included: gender, education, previous professional/clinical experience, years of professional/clinical practice, (majority of) type of client system treated, number of couples treated, how often respondents/practitioners treat couples, type of treatment format, length of sessions (number of sessions), clinical supervision, peer supervision and theoretical orientation.

Statistical tests were performed, comparing social workers versus other therapists. The following variables had significant differences in means: years of clinical practice (Item #4), frequency of counselling couples (Item #7a), treatment format (Item #7b), and hours of clinical supervision (Item #8b).

Differences in years of practice (Item #4) proved to be significant. For social workers, the mean was 16.02 years of practice (S.D. = 9.07); for other therapists, the mean was 12.23 years (S.D. = 8.35). The mean difference between social workers and other therapists was 3.79 years, $t(190.1) = 4.43$, $p = .001$ The social workers in the couples counselling sample had more years of professional experience than the other therapists.

The differences in frequency of counselling couples (Item #7a) proved to be statistically significant. Social workers tended to see at least one couple for counselling once every 2.12 weeks (on average), and other therapists tended to see at least one couple for counselling once every 1.54 weeks (on average). The mean difference was .66, $t(197.4) = 4.31$, $p = .001$ On average, other therapists in the couples counselling sample treat couples more frequently than social workers.

Treatment format (Item #7b) proved to be statistically significant. In terms of the treatment format used to treat couples, social workers used conjoint therapy 76.5% of the time as opposed to other therapists who used this type of format 88.0% of the time. $t(226.2) = 4.66$, $p = .001$ Other therapists in the couples counselling sample employed conjoint therapy more frequently than social workers.

Differences in hours of clinical supervision received (Item #8b) proved to be statistically significant. In terms of hours of clinical supervision received, social workers had a mean of 2.91 hours per month and other therapists had a mean of 3.27 hours per month; the mean difference was .36 hours per month, $t(284) = 2.17$, $p = .031$ Other therapists received more (hours of) clinical supervision than social workers.

No statistically significant differences were found between these two groups (social workers and other therapists) based on the following demographics: gender, current employment as a clinical social worker/therapist/counsellor, previous employment experience as a clinical social worker/therapist/counsellor, type of client system previously treated, present and previous employment setting, type of client system currently treated, number of couples treated per year,

length of treatment in terms of number of sessions, and peer supervision.

The following is a comparison between social workers and other therapists, in terms of how these two groups differed in their responses on the various individual items. These differences were examined by the employment of t-tests.

On Item #12b, where the respondent was asked whether or not his/her subjective reactions would influence his/her response or interaction with the vignette couple, other therapists scored higher (by choosing "Yes" more frequently) than social workers. Other therapists chose "Yes" 83.6% of the time, and social workers chose "Yes" 73.5% of the time, $t(207.1) = 2.61$, $p = .010$ On Item #17, where the respondent was asked to select the most accurate definition for transference (e.g. characterized as affect, behaviour, cognition, etc.), 31.4% social workers chose option #6 which was the most accurate response, and 23.0% other therapists chose the most accurate response, $t(194.1) = 1.95$, $p = .052$ social workers attained a higher percentage of accurate responses than other therapists.

On Item #28, where the respondent was asked to select the most accurate definition of countertransference, 87.7% other therapists chose one of the three most accurate definitions (i.e. options 5, 6 and 7), as compared with 80.5% social workers. In comparing the two groups, a higher percentage of other therapists selected an accurate definition than social workers. $t(209.5) = 2.11$, $p = .036$

As a brief summary, when comparing social workers and other therapists in the primary sample of couples counsellors, the following variables were found to be significant: years of clinical practice (Item #4), frequency of counselling couples (Item #7a), treatment format (Item #7b), and hours of clinical supervision (Item #8b). The social workers had more years of professional experience than the other therapists. Other therapists treat couples more frequently than social workers. Other therapists employed conjoint therapy more frequently than social workers. Other therapists received more clinical supervision than social workers. On Item #12b, other therapists indicated more frequently than social workers, that their subjective reactions would influence their

responses or interactions with the vignette couple. On Item #17, social workers attained a higher number of accurate definitions of transference, than other therapists. On Item #28, other therapists attained a higher number of accurate definitions of countertransference, than social workers.

4.4 How Social Workers and Other Therapists Approached the Use of the Psychoanalytic Model, and the Identification of Transference and Countertransference:

Theoretical Orientation – as related to couples in general (Item #9a):

This question asked the respondent to choose the theoretical model that he/she finds useful when working with couples, in general. Only those respondents who indicated on Item #6b that they treat couples, were included in this analysis. The respondent was asked to rank order the various theoretical models listed, according to Most Useful, Second Most Useful and Third Most Useful.

Couples Counsellors:

Among the primary sample (n = 654), 621 respondents responded to this item. Among this sample of couples counsellors, only 38 (6.1%) respondents selected the psychoanalytic model as their first choice (Most Useful) and 109 (17.6%) respondents selected it as one of their top three choices.

Of the 514 social workers who responded to this item, 29 (5.6%) selected the psychoanalytic model as their first choice (Most Useful) and 88 (17.1%) selected it as one of their top three choices. In comparison, of the 116 other therapists who responded to this item, 9 (7.8%) selected the psychoanalytic model as their first choice and 21 (18.1%) selected it as one of their top three choices.

Theoretical Orientation – as related to the couple in the vignette (Item #11a):

This question asked the respondent to choose the theoretical model that he/she would find useful when working with/treating the couple in the vignette, specifically. The respondent was asked to rank order the various theoretical models listed, according to Most Useful, Second Most Useful and Third Most Useful.

Couples Counsellors:

Among the primary sample (n = 654), 630 respondents responded to this item. Among this sample of couples counsellors, only 43 (6.8%) respondents selected the psychoanalytic model as their first choice (Most Useful) and 113 (17.9%) respondents selected it as one of their top three choices.

Of the 512 social workers in this couples counsellors sample who responded to this item, 33 (6.4%) selected the psychoanalytic model as their first choice (Most Useful) and 93 (18.2%) selected it as one of their top three choices. In comparison, of the 118 other therapists who responded to this item, 10 (8.5%) selected the psychoanalytic model as their first choice and 20 (16.9%) selected it as one of their top three choices.

Identification of Transference and Countertransference (Item #11b):

On Item #11b, the respondent was asked to identify his/her overall impression of what is going on with the couple in the vignette. The respondent was asked to list 3 key issues, and to rank order them in order of importance. Here, the identification of transference and/or countertransference was being sought by the researcher, as key or central issues within this therapeutic scenario. There were 3 possible correct answers for this question, and therefore each respondent had 3 opportunities to achieve points for these accurate responses.

Couples Counsellors Sample:

Among the primary sample, social workers who treat couples (n = 522) achieved 50 (3.2%)

accurate responses out of a possible 1,566 (3 possible answers x 522 respondents on this item), and other therapists who treat couples (n = 120) achieved 17 (4.7%) accurate responses out of a possible 360 (3 possible answers x 120 respondents). A slightly higher proportion of other therapists identified transference and/or countertransference, compared to the group of social workers.

5. **Theoretical Knowledge versus Practical Application:**

In order to compare respondents'/practitioners' theoretical knowledge of transference and countertransference with their practical application of transference and countertransference, the procedure of crosstabulation was performed in a contingency table; this procedure was also performed as part of a reliability analysis, in determining internal consistency (on p. 117). Two questions were selected as a pair, which asked the respondent for almost identical information concerning transference and/or countertransference, where the first question posed was based on theoretical knowledge and the second question required the respondent's demonstration of this same theoretical knowledge to actual clinical practice. This exercise would illustrate the congruence or consistency of theoretical knowledge with clinical application for the respondent, or a lack of congruence of theoretical knowledge with practical application. Respondents were then determined to either have a "good match" or "bad match", depending on how their theoretical knowledge and practical application compared: this test was accomplished through crosstabulation.

The pair of questions included two, which were closely related, in terms of corresponding to each other: one was a theoretical question and the other a practical-oriented one, directly associated with the vignette (e.g. Items #14 with #16b, #30 with #16a). For example, on Item #14, the respondent was asked whether he/she is as attentive to his/her own feelings as to those of the client/client couple, and the respondent was required to choose his/her response from options ranging from "Strongly Agree" to "Strongly Disagree" to respond to the given statement regarding

subjectivity. Item #14 is the question which asked for the respondent's claim of theoretical knowledge and Item #16b required him/her to be consistent in his/her response when commenting on the subjective reactions of the therapist in the vignette toward the clients/client couple. For Items #30 and #16a, Item #30 asked the respondent how often he/she is aware of his/her subjective feelings and internal reactions when treating couples, and then on Item #16a the respondent was asked to demonstrate his/her claim by commenting on any subjective reactions that the therapist in the vignette may have toward the clients/client couple.

For each individual question, a score was considered to be "good" if the respondent selected a choice (i.e. one of the options given for each question) that had been pre-determined to be correct using accepted definitions to be correct (e.g. On Item #14, any of the options ranging from "Somewhat agree" to "Strongly agree" was determined to be a correct answer). A score was considered to be "bad" if the respondent selected a choice that had been pre-determined to be incorrect (e.g. On Item #14, any of the options ranging from "Somewhat disagree" to "Strongly disagree" was determined to be an incorrect answer). The procedure of crosstabulation could then be done to determine the type of "match" that the respondent had scored for each pair of questions. A "good-good" match or a "bad-bad" match was determined to be "consistent" where the respondents' responses were similar in both theoretical knowledge and practical/clinical application, whether this was determined to be a "good-good" match or a "bad-bad" one. A "good-bad" match was defined as a "good" demonstration of the theoretical knowledge combined with a "poor" demonstration of practical/clinical application. A "bad-good" match was defined as a "poor" demonstration of theoretical knowledge combined with a "good" demonstration of practical/clinical application.

Items #14 and #16b were crosstabulated in a contingency table (n = 575) to find that 298 (51.8%) respondents had a "good-good" match, choosing a correct response on Item #14 (theoretical question) and then writing out a correct response on Item #16b (practical application), demonstrating their awareness of and attention to their subjective reactions. For this

crosstabulation, 189 (32.9%) respondents had a "good-bad" match (i.e. "good" in theory, "bad" or poor in practice), 51 (8.8%) had a "bad-good" match, and 37 (6.4%) had a "bad-bad" match, demonstrating their (consistent) lack of awareness of and attention to their subjective reactions.

The total number of respondents who were consistent in their responses on both theoretical knowledge and practical application of countertransference (i.e. "good-good" or "bad-bad") was 335 (58.2%). Of greater interest is the remainder of respondents (i.e. 189 = 32.9%) who demonstrated a "good-bad" match in theory and practice respectively, and 51 (8.8%) who demonstrated a "bad-good" match in theory and practice respectively. Almost four times as many respondents claimed an awareness and/or acknowledgment of countertransference, but did not demonstrate this ability through a clinical application on a vignette-related question, as opposed to those respondents who demonstrated greater clinical application over theoretical knowledge.

Similarly, when Items #30 and #16a were crosstabulated (n = 592), 71 (12.0%) respondents had a "good-good" match, choosing the correct response on Item #30 (theoretical question) and then writing out the correct answer on Item #16a (practical application), where they demonstrated their awareness and/or acknowledgment of their subjective reactions. For this crosstabulation, 460 (77.7%) respondents had a "good-bad" match (i.e. "good" in theory, "bad" or poor in practice), 9 (1.5%) had a "bad-good" match, and 52 (8.8%) had a "bad-bad" match, demonstrating their (consistent) lack of awareness of and attention to their subjective reactions.

The total number of respondents whose responses were "consistent" in both theoretical knowledge and practical application (i.e. "good-good" or "bad-bad") was 123 (20.8%). The reason the percentage of "consistent" responses was much lower in this example than in the previous one is due to this question (Item #16a – practical application) being found by respondents to be a much more challenging one them. In this case, there was an even more dramatic demonstration of respondents' inconsistency where their theoretical knowledge was not clinically applied when the opportunity was presented through the vignette (i.e. 460 = 77.7% respondents who demonstrated a "good-bad" match in theory and practice respectively, and 9 = 1.5%

respondents who demonstrated a "bad-good" match in theory and practice respectively). Approximately 50 times as many respondents (77.7% versus 1.5%) claimed an awareness and/or acknowledgment of subjective reactions, but did not show a clinical application on a vignette-related question.

Additional crosstabulations were conducted, the results of which followed a similar pattern as the initial two that were run. (Items #14 and #12a, #14 and #16a, #23 and #16a, #24 and #12a, #24 and #16b, #30 and #12a, #30 and #12b, and #32 and #12b). Based on these crosstabulations, results clearly demonstrated that respondents who were inconsistent (in their responses on theoretical and practical-oriented items) tended to score significantly higher on their theoretical knowledge than on their practical/clinical application when presented with a question related to the vignette.

6. Linear Model: An Examination of Predictor Variables for Application/Use of Transference and Countertransference by Practitioners who Counsel Couples

The previously outlined procedure of crosstabulation involves only taking one variable at a time. The next step is to take several variables at a time and try to predict the vignette score based on the variables considered which include x_1, x_2, x_3, x_4, x_5, x_6, and x_7. A detailed description of these variables follows.

In designing this research study, we were interested in examining several variables in terms of how well respondents/practitioners thought they did theoretically and conceptually, and how this would correspond to how they would perform in terms of their clinical/practical application. Would their theoretical and conceptual knowledge base enable us to predict their clinical application score? Several models were explored in this analysis. (Our dependent variable was the vignette score which indicates how accurately the respondent answered questions regarding the vignette, in terms of transference and countertransference. See Appendix B, Coding and Scoring.) All of the demographics, all of the variables under consideration, and all of the items on the

questionnaire were included for analysis as potential predictors. The best model looks at the predictors of a measure of the respondent's ability to observe/use transference and countertransference through his/her reaction(s) to the supplied vignette. The Backward and Stepwise techniques were employed, as well as our knowledge of the problem. Of all of the models considered, the following model was best, in terms of yielding the highest r squared and including the fewest variables. (See Table 52, Linear Model).

Predictors of Vignette Score:

y = Vignette score: where the higher the score, the better the demonstrated ability.

The Vignette score includes the following items: #11b, #11c, #12a, #12b, #16a and #16b, and was scored out of 30. (See Appendix B, Coding and Scoring, for a detailed description of how this was weighted and calculated.)

x_1 = B.S.W. degree or not
x_2 = B.S.W. and M.S.W. degrees (both) or not
x_3 = Treatment Format (Q7b)
x_4 = Usefulness of the psychoanalytic model with the vignette couple (Q11a)
x_5 = Practitioner's frequency of considering the effects of transference when working with clients (Q23)
x_6 = Practitioner's feelings and treatment strategies (Q32)
x_7 = Theoretical knowledge score (combination of items re: theoretical knowledge)

Theoretical knowledge score includes the following items: #17, #18, #19, #20, #21, #22, #25, #26, #27, and #28, and was scored out of 30. All items were weighted equally. (See Appendix B, Coding and Scoring.)

There were 654 respondents included for analysis. There were 7 variables found to be significant. The $F(7, 623) = 21.162$ was significant at $p = .001$, indicating that the model was adequate and at least one β was not equal to 0. R Square = .192, indicating that 19.2% of the variance in the Vignette score is accounted for by this model.

The following variables in Table 52 are necessary to the model:

Table 52

Predictors of Vignette Score
Linear Model for Couples Counsellors

Variable		B Coefficients	T	Significance Level
B.S.W. degree or not	(x_1)	-1.125	-2.554	.011
B.S.W. and M.S.W. degrees (both) or not	(x_2)	-1.546	-4.330	.001
Treatment format	(x_3)	0.624	2.432	.015
Usefulness of the psychoanalytic model with the vignette couple	(x_4)	2.334	5.915	.001
Practitioner's frequency of considering the effects of transference when working with clients	(x_5)	-0.395	-2.333	.020
Practitioner's feelings and treatment strategies	(x_6)	1.270	5.313	.001
Theoretical knowledge score	(x_7)	0.168	6.152	.001

Assumptions:

Both the normal probability plot and a histogram of the data, and other residual statistics indicated the standard assumptions for the linear model had been satisfied. (For further details, see Appendix CC, Histogram and Probability Plot, and other residual statistics for Linear Model for Couples Counsellors).

Examination of the Coefficients:

All 7 variables in this model were found to be significant. An examination of the coefficients (Table 52) in this model indicated that Usefulness of the psychoanalytic model with the vignette couple (x_4) is the variable that is the largest contributor to the Vignette score when all of the other variables are held constant. Vignette score increased 2.33 when the respondent chose the psychoanalytic model as one of the top three models of choice when working with the vignette couple (x_4). The vignette score decreased 1.55 if the respondent had a combination of B.S.W. and M.S.W. degrees as compared to other degrees (i.e. M.S.W. degree only, or M.A. degree) (x_2). The vignette score increased 1.27 for every increase in awareness that the respondent/practitioner had

to his/her own feelings when treating couples (x_6). Vignette score increased 0.17 for each point scored on the theoretical knowledge index (x_7). Vignette score decreased 1.13 if the respondent had a B.S.W. degree (x_1). Vignette score increased by 0.62 with each increment of selecting conjoint therapy as treatment format (x_3). Unexpectedly, the vignette score decreased 0.40 for each increment of the practitioner claiming that he/she considered the effects of transference when working with clients (x_5). All x variables are positively related to y except x_1, x_2, and x_5.

7. Other Subsamples:

For additional interest, we have also included a snapshot of the two smaller groups that are of interest to this researcher. A brief outline of two small subsamples follows, which includes: (a) academics who are also clinical practitioners, and (b) psychoanalytically oriented practitioners. (Table 53). Following a summary of relevant descriptive statistics for these two smaller subsamples, the findings from a secondary analysis that was performed for each of these groups will also be presented.

Table 53

Two Additional Groups:

Group	n	% of Overall Sample	n	% of Primary Sample (Couples Counsellors)
Respondents who are psychoanalytically oriented	38	4.0	38	5.8
Respondents who work within the academic realm	24	2.6	19	2.9

a.) Academics who also engage in clinical practice:

The total number of respondents in this group is 24 (2.6%) of the overall sample of 941 respondents. Of the sample of couples counsellors (n = 654), the academic representation is 18 (2.8%) with these respondents spending the majority of their professional experience within the academic realm while also engaging in clinical practice.

This group is comprised of 19 social workers and 5 other therapists. Of these, 8 respondents have Ph.D. degrees, 5 of which are in social work.

Sixteen (66.7%) respondents had indicated "individuals" as the majority of client/patient systems whom they treat in their current clinical experience, and 8 (33.3%) indicated "couples". In terms of years of practice for these respondents, the mean was 21.7 years. (S.D. = 9.6 years).

The mean number of couples treated by respondents in this sample is 17 couples per year. (S.D. = 16 couples). In terms of the frequency with which clinicians counsel couples, the greatest number of respondents (8 = 44%) treat couples two or more times per week, with the next greatest number of respondents treating couples once every two weeks (6 = 33.3%).

Twelve respondents (70.6%) treat couples in conjoint sessions (as a couple together), with 5 (29.4%) treating the couple system through an equal combination of individual and conjoint counselling sessions. Of these respondents who treat couples, none sees partners/mates individually. The largest number of respondents in this group (11 = 68.8%) treat couples in 1 - 10 sessions, 4 (25%) treat couples in 11 – 20 sessions, and 1 (6.3%) treats couples in 21 or more sessions. In terms of supervision, 2 (8.3%) respondents receive clinical supervision, and the mean is one hour per month.

Theoretical Orientation (Item #9a):

Regarding the type of theoretical model found to be most useful in working with couples, approximately the same small number of respondents (i.e. 1 or 2) chose each of the various models respectively, including 2 (11%) who chose the psychoanalytic model. Of interest to note is that the 2 respondents who selected the psychoanalytic model as their first choice/model of preference in general (as indicated on Item #9a), also correctly identified all 3 tenets of the psychoanalytic model. Additionally, these same two respondents selected the psychoanalytic model as their first model of choice in treating the vignette couple (Item #11a).

Identification of Transference and Countertransference as Key Issues for the Vignette Couple (Item #11b):

On this question, where respondents were asked to identify three key issues in terms of what is going on with the vignette couple, there were 24 respondents who responded on this item. Out of a possible 72 opportunities (3 possible answers x 24 respondents on this item) for these respondents to identify transference and/or countertransference, only 3 (4.2%) accurate identifications of these concepts were made. In general, the majority of respondents did not make even one accurate identification of transference or countertransference as key issues for the vignette couple.

Scoring on the Key Indices – Where the Theoretical Meets the Clinical Application:

In terms of scoring for this group of academics who also engage in clinical practice, these respondents scored a mean of 5.44 (S.D. = 1.46) on awareness. Their mean score on acknowledgment was 6.32 (S.D. = 2.46). On understanding, this group scored a mean of 5.48 (S.D. = 1.67). On attitude, the mean score was 7.15 (S.D. = 2.02). In terms of the mean score on the overall index, this group scored 6.10 (S.D. = 1.38). This group scored a mean of 1.67 (S.D. = 1.48) on use/practical application. In comparing the scoring on the key indices by the sample of academics who engage in clinical practice with that of the primary sample of couples counsellors, the academics scored only slightly higher on most of the key indices.

Overall, this sample of academics scored "Average" in terms of their awareness and understanding, "Average-High" on acknowledgment, and "High" on attitude. This group scored "Average" on the overall index. The score for this group was rated (very) "Low" on use which is their demonstrated application of transference and countertransference (on the vignette).

An attempt was made to run a linear regression model on this sample in search of significant variables that predict vignette score. For this sample, a linear model was not a good predictor. No reasonable model could be produced from the data; this could be due to the small number of respondents in this sample, or the variability of the data.

b.) Psychoanalytically oriented Practitioners who engage in couples counselling

The total number of respondents in this group is 38, which represents 5.8% of the couples counselling sample (n = 654). This group is comprised of 29 (76%) social workers and 9 (24%) other therapists. The selection of this group was based on respondents' choice of the psychoanalytic model as their first choice on Item #9a (n = 630). Of interest is that there were 109 respondents (17.3%) who selected the psychoanalytic model as one of their top three choices.

This small sample was comprised of 13 (34%) male respondents and 25 (66%) female respondents.

Findings regarding these psychoanalytically oriented respondents' education including degrees held were, as follows: 29 (76%) are social workers with either a B.S.W. or an M.S.W. degree, or both degrees, and 9 (24%) are other therapists with different types of non-social work degrees. Among this latter group of other therapists, 12 respondents have an M.A. degree in a variety of disciplines and 6 have psychoanalytic certificates/training. Six respondents in this sample have Ph.D. degrees, 4 of which are in social work.

In this group, 17 (53%) work in private practice, 7 (22%) work within a hospital - mental health setting, with the remaining 8 (25%) working in other settings. Six are missing data.

Twenty-three (60.5%) respondents had indicated "individuals" as the majority of client/patient systems they treat in their current clinical experience. Eleven (28.9%) respondents indicated "couples", and 4 (10.5%) chose "families". In terms of years of practice, the mean was 19 years. (S.D. = 9.7 years).

The mean number of couples treated by respondents in this sample is 20 couples per year. (S.D. = 16 couples). In terms of the frequency with which clinicians counsel couples, the greatest number of respondents (25 = 68%) treat couples on a weekly basis – i.e. once per week, with the next largest number of respondents/clinicians (5 = 13.5%) treating couples once every two weeks.

Thirty-one respondents (83.8%) treat couples in conjoint sessions (as a couple together), with 6 (16.2%) treating the couple system through an equal combination of individual and conjoint

counselling sessions. No respondents from this sample treat couples as partners/mates individually.

The largest number of respondents in this group (14 = 36.8%) treat couples in 11 - 20 sessions, 13 (34.2%) treat couples in 1 - 10 sessions, and 11 (28.9%) treat couples in 21 or more sessions which this researcher has classified as Long-Term or more intensive therapy. As would be expected, more of these psychoanalytically oriented respondents chose longer treatment in terms of number of sessions with couples, as opposed to the majority of couples counsellors (72.4%) who selected Short-Term treatment (i.e. 1 – 10 sessions) to describe the type of therapy they currently use most often when working with couples.

In terms of clinical supervision, 12 (31.6%) respondents have a clinical supervisor, as determined by their indicating "Yes" on Item #8a; 26 (68.4%) do not have a clinical supervisor. Of the respondents who have a clinical supervisor, the largest group (7 = 46.7%) received 2 - 3 hours of supervision per month. Thirty-two (84%) receive peer supervision/consultation, with a mean of 3.1 hours per month with a S.D. = 2.4 hours.

Theoretical Orientation (Item #9a):

Regarding the type of theoretical model found to be most useful in working with couples, all of these respondents selected the psychoanalytic model as their first choice in working with couples, in general (Item #9a). It is significant to note that 25 (65.8%) respondents from this group selected the psychoanalytic model as their first model of choice in treating the couple in the vignette. (Item #11a). Interestingly, 10 (26.3%) of these respondents did *not* select the psychoanalytic model as a first choice for the vignette couple although, in general, they *claimed* that this model would be their first choice/Most Useful in treating couples.

The majority of these respondents (25 = 65.8%) correctly identified three main tenets or key concepts that characterize the psychoanalytic model (on Item #9b); 10 (26.3%) correctly identified one or two tenets, and 3 (7.9%) did not identify any tenets characteristic of the psychoanalytic

model. Another way of looking at this is that 92 (80.7%) correct tenets were identified out of a possible 114 (3 possible responses x 38 respondents).

Identification of Transference and Countertransference as Key Issues for the Vignette Couple (Item #11b):

On this question, where respondents were asked to identify three key issues in terms of what is going on with the vignette couple, there were 38 respondents who responded on this item. Out of a possible 114 opportunities (3 possible answers x 38 respondents on this item) for these respondents to identify transference and/or countertransference, only 15 (13.2%) accurate identifications of these concepts were made. In general, the majority of respondents did not make even one accurate identification of transference or countertransference as key issues for the vignette couple. Nonetheless, these psychoanalytically oriented respondents were approximately 4 times more likely than the couples counselling sample of respondents to identify transference and countertransference as key issues in this clinical case.

Scoring on the Key Indices – Where the Theoretical Meets the Clinical Application:

In terms of scoring for this group of psychoanalytically oriented couples counsellors, these respondents scored a mean of 6.43 (S.D. = 1.73) on awareness. Their mean score on acknowledgment was 7.86 (S.D. = 2.38). On understanding, this group scored a mean of 5.57 (S.D. = 1.30). On attitude, the mean score was 8.56 (S.D. = 1.27). In terms of the mean score on the overall index, this group scored 7.11 (S.D. = 1.09). This group scored a mean of 5.23 (S.D. = 1.37) on use/practical application.

Overall, this sample of psychoanalytically oriented couples counsellors scored "Average-High" (a little better than "Average") in terms of their awareness, relatively "High" on acknowledgment, "Average" on understanding, and very "High" on attitude. In terms of the overall index, this group scored "High". The score for this group of couples counsellors was rated "Average" on use which is their demonstrated application of transference and countertransference. Of interest, is

that this group scored "Average" on use/practical application, and this was a much higher score than for any of the other samples/groups. This pattern is consistent and carries over into this group's score on the overall index, which is rated "High" and demonstrates a higher score than for any of the other subgroups/subsamples. (It should be noted that respondents who had selected the psychoanalytic orientation received points for selecting this choice.)

An attempt was made to run a linear regression on this sample in search of significant variables that predict vignette score. For this sample, a linear model was not a good predictor. No reasonable model could be produced from the data; this could be due to the small number of respondents in this sample, or the variability of the data.

Additional Observations and Comments:

Although the psychoanalytically oriented sample is a very small group, nevertheless the findings are relevant. In general, this group scored higher than the other groups on awareness, acknowledgment, attitude, understanding and use/practical application, as well as on the Overall Index (i.e. all of the key indices). As an example which illustrates this point, social workers who treat couples scored a mean of 5.96 (S.D. = 1.27) on the overall index and other therapists scored a mean of 5.85 (S.D. = 1.64). The psychoanalytically oriented group had a mean score of 7.08 (S.D. = 1.09) on the overall index. Comparatively speaking, while the mean score for the academic sample on the Overall Index was 6.10 (S.D. = 1.38) and considered to be a "Medium-High" score, the mean score for the psychoanalytic sample was 7.08 (S.D. = 1.09) and considered to be a "High" score.

Chapter 5

Discussion

The Perception and Use of the Concepts of Transference and Countertransference as Therapeutic Tools in Couples Counselling

This research study reports the proportion of practitioners (social workers and other types of therapists) who are aware of, acknowledge, and use the concepts of transference and countertransference in their work with couples; it also reports to what extent these practitioners accurately comprehend the meaning and potential use of these concepts in their clinical practice. Findings include the proportion of practitioners who are aware of, acknowledge, and use the psychoanalytic model in their treatment of couples, and to what extent this model is a clinical consideration in their choice of treatment models within the couples counselling context.

This study's findings suggest that there are several gaps in the (theoretical and conceptual) knowledge base of both social work practitioners and other therapists who work with/treat couples, in terms of their awareness of, acknowledgment of, understanding of, attitude toward, and use of the psychoanalytic paradigm, as well as of the concepts of transference and countertransference. Additionally, the research study found a significant incongruity between the self-identified theoretical base of practitioners surveyed and their practical application of the concepts of transference and countertransference when the opportunity to consider and use these concepts was clinically presented in the vignette. Many respondents claimed to have an awareness of, acknowledgment of, understanding of, attitude toward, and use of the psychoanalytic model, as well as of the concepts of transference and countertransference, and yet, this assertion was not often demonstrated in practical/clinical application, as indicated by their response to the vignette.

A range of demographic and other variables (e.g. type of education, work experience, and supervision) were examined in an attempt to reveal and understand the factors that impact upon

practitioners' therapeutic practices, and to offer insight into the framework within which these practitioners clinically function.

The first section presents the key findings of the study; namely, the primary client system treated by respondents, the theoretical orientation reported by the respondents, and how the respondents consider transference and countertransference, as well as the gap between respondents' theoretical knowledge and their demonstrated clinical/practical application. In the second section, the variables that were significantly associated with practitioners' awareness of, acknowledgment of, understanding of, attitude toward, and use of the concepts of transference and countertransference, and of the psychoanalytic model are discussed. The third section includes a brief review of the differences found between social workers and other therapists who do couples counselling, and these subgroups are also compared with respondents who are, or were, academics. The subgroup of psychoanalytically oriented practitioners will also be briefly discussed in this section, in comparison with other practitioners with different types of theoretical orientations. In the fourth section, predictors of the ability to accurately apply psychoanalytic theory, and transference and countertransference are reviewed and discussed. The chapter ends with a discussion of the limitations of the study, implications for clinical practice, suggestions for future research, and final thoughts and conclusions. All discussion is framed within the perspective of the object relations model.

Key Findings:

Several key findings were identified from the results of this study, which have implications for social work practice and social work education. While a number of findings will be discussed in this chapter, the major ones are being highlighted first; i.e. the primary client system treated, the theoretical orientation with a specific focus on the psychoanalytic paradigm, the identification and consideration of transference and countertransference, and the gap found between respondents' theoretical knowledge and clinical/practical application. The primary client system

treated by practitioners, the theoretical orientation selected by practitioners both conceptually and clinically, the consideration or lack of consideration of transference and countertransference in the therapeutic process, and the gap found between respondents' theoretical knowledge and their demonstrated clinical/practical application, reveal much in terms of how practitioners practise. A basic assumption is that practitioners' awareness, acknowledgment, understanding, and attitudes concerning the psychoanalytic paradigm, and concerning transference and countertransference have an effect on their clinical practice.

Primary Client System Treated:

Most noteworthy among the primary sample of couples counsellors (which was comprised of social workers and other therapists) was that the majority of respondents identified individuals rather than couples, as the primary client/patient system whom they currently treat (Item #6a, Table 13, social workers and Table 35, other therapists). A comprehensive literature review (Ch. 2) demonstrated that there is more literature and research available on the treatment of individuals than couples, and on transference and countertransference in the area of individual therapy than in couples counselling. "The literature on couple/marital therapy is relatively scarce when compared to the literature on family therapy." (Weeks & Hof, 1994, p. ix). However, more recently, journal articles and workshops in this area of couple and marital therapy have grown. (Weeks & Hof). Nevertheless, the focus of psychotherapy, in the areas of clinical practice and research, still seems to be on the individual or with families, rather than on couples and the issues concerning dyadic relationships. (Weeks & Hof, 1994; Brothers, 1996). The findings of this study support the premise that more practitioners treat individuals as their primary client system, which would imply a greater exposure to, experience with, and understanding of this type of client/patient system over another (i.e. specifically, individuals rather than couples). An appropriate question arising from this finding might relate to the comfort level of practitioners in choosing treatment models, therapeutic techniques, and tools with which to treat couples when

practitioners are not working with couple systems to the extent that they are working with individuals. The literature (Ch. 2) also reveals that although practitioners do not use the psychoanalytic model to the same extent that they select and use other models in treating clients, when the psychoanalytic model *is* selected, it is usually in the treatment of individuals but rarely considered or used in the treatment of couples. Perhaps it is because practitioners are more familiar with the main client system whom they treat (i.e. individuals) and the theoretical models that they believe to be most appropriate for working with this client system, that they are not as familiar with the psychoanalytic model in treating couples. Alternatively, perhaps practitioners do not consider the possibility of using the same model to treat a couple system that they would use in working with individual clients.

Of interest to note is that 259 (27.5%) respondents in this study do not treat couples at all (Figure 1, p. 118), and those respondents who *do* treat couples saw an average of only 25 couples per year (Appendix Z, p. 295). One respondent with her M.S.W. degree, currently in private practice, who does not see couples as part of her practice, wrote, "Treating couples is too complex. I refer them out...and actually, do not know too many therapists who treat couples." Another respondent with his M.S.W. degree, who is employed within the academic realm and also engaged in clinical practice, and who treats approximately 4 couples a year, wrote, "I prefer to not see couples. They are very difficult, and can be overwhelming."

Theoretical Orientation Reported by Respondents:

Another key finding relates to how often the psychoanalytic model was identified as the orientation perceived as most useful; specifically, how very few practitioners identified their theoretical orientation as the psychoanalytic one, indicating that practitioners are not as aware nor do they acknowledge the psychoanalytic paradigm to the extent that they could, in the understanding and treatment of couples. The literature reveals that the psychoanalytic model is not a commonly selected model in counselling; when it *is* selected, it is most commonly applied

in individual treatment. A major hypothesis for this research study was that practitioners may not be aware of this paradigm as a useful model of understanding and intervention in the treatment of couples. There may be practitioners who have some level of awareness but not a sophisticated one, and therefore they have not mastered use of this model; another possibility is that they have rejected it for a variety of reasons that include a lack of awareness. Bohart (1997) states, "Psychotherapy is increasingly moving towards an integrative, eclectic stance", but "None of this work has specifically focused on couples therapy." (as cited in Brothers, 1996, p. 41). Findings of this study supported this statement, in that a very small number of practitioners considered the psychoanalytic model when treating couples in general (Item #9a), and specifically, in treating the couple in the vignette (Item #11a). The results in Tables 20 and 42 highlight that the majority of social workers and other therapists respectively, *did not* consider or endorse the psychoanalytic model as their first choice when asked to select their "Most Useful" theoretical model in working with couples in general (Item #9a). Additionally, the majority of respondents *did not* endorse this model as their first choice in treating the vignette couple (Item #11a). (Table A3, Appendix A).

An interesting finding was that among the sample of couples counsellors, out of 654 respondents, only 38 (6.1%) respondents selected the psychoanalytic model as their *first choice* in treating couples in general (Table Z19, Appendix Z), and 43 (6.8%) respondents selected this model as their *first choice* in treating the couple in the vignette (p. 312, Appendix Z). Although it is encouraging to note that a greater number of respondents (109 = 17.6%) in the primary sample of couples counsellors demonstrated that the psychoanalytic model was *a consideration* for them as a useful model in treating couples in general (Item #9a, p. 307, Appendix Z), nevertheless, this is still a very small number of respondents. As well, a higher number of respondents (113 = 17.9%) demonstrated that the psychoanalytic model was *a consideration* for them as a useful model in treating the vignette couple (Item #11a, pp. 312-313, Appendix Z); nevertheless, this group of respondents was also very small. Of all the theoretical models, the psychoanalytic one was one of the least popular models selected among respondents. Findings in this research study

converged with those of Norcross, Prochaska, and Gallager (1987) who conducted a national survey of clinical psychologists in which only 21% of the sample indicated their preference for the "psychodynamic orientation".

This theoretical model is seldom used; when it *is* considered and applied, it is predominantly in the treatment of individuals. As supported by results in this study, very few respondents demonstrated an awareness of, an acknowledgment of, or a considered application of this model in treating couples in general (as indicated on Item #9a), or in treating the couple in the vignette (as indicated on Item #11a).

Although it may be of interest that a higher percentage of other therapists than social workers selected the psychoanalytic model as their first choice both in working with couples in general, (Table A1, Appendix A) and in treating the vignette couple (Table A3, Appendix A), the difference was not large. It is clearly demonstrated in this study that most practitioners who treat couples are not using what many clinicians (Scharff, D. E., 1991; Scharff & Scharff, 1991; Lachkar, 1992) and researchers (Snyder & Wills, 1989; Johnson & Greenberg, 1991) consider to be a valuable paradigm with which to better understand and intervene with couples.

In the context of couples counselling, one of the advantages of psychoanalytic psychotherapy is, "...that it is interpretive rather than instructive. It focuses on unconscious processes that occur both within and between each member of the couple." (Epstein & Feiner, 1979, p. 177). The few research studies that have been done to examine the effectiveness of psychodynamically informed practice with couples (Snyder & Wills, 1989; Johnson & Greenberg, 1991) concluded that the process of uncovering and discovering with insight and new understanding would help to make the couple bond stronger on an affective level. Nevertheless, Table 20 demonstrates that the largest number of social workers in this study selected the cognitive behavioural model (Item #9a) as their first choice in treating couples in general, and the largest number of other therapists chose the systems model (Table 42). As would be expected, those few practitioners who had selected the psychoanalytic model as their theoretical orientation scored the highest on the key

indices. Those social workers with the behavioural orientation scored the lowest on acknowledgment, attitude, use, and the overall index, of all of the social workers with other orientations. (Tables 21 through 24). Additionally, those social workers with the systems orientation did not score as well on all of the indices, in comparison to the psychoanalytically oriented social workers.

One of the reasons practitioners do not consider or use the psychoanalytic model to a great extent, is because it is not being widely taught or promoted in schools of social work today, nor is it being used as extensively as it previously has been in clinical practice in North American psychotherapy. According to the American Psychoanalytic Association (A.P.A.), psychoanalytic practice has declined at the rate of 1% a year and this trend has continued for the past 17 years (Margolos, as cited in Hanna, 1997). According to Hanna (1997), there is a "crisis in psychoanalysis" (p. 76), and, "The factors leading to the current challenges to psychoanalysis closely approximate those threatening the survival of psychoanalytically informed clinical social work practice". (Ibid.). As Hanna affirms, it is evident that the current crisis in clinical social work parallels the crisis in psychoanalysis and yet, in comparison with other therapeutic models, the psychoanalytic model has been referred to by Fine (1981) as "the analytic ideal". Nevertheless, as illustrated in Table 20, the majority of respondents did not select "the analytic ideal", and instead selected other models as their model of choice, both for treating couples in general (Item #9a) and for treating the vignette couple (Item #11a).

When the psychoanalytically oriented couples counsellors (i.e. those few respondents among the couples counsellors who selected the psychoanalytic model as their first model of choice in working with couples), were also asked to identify three main tenets or key concepts of this (psychoanalytic) model (Item #9b, p. 312, Appendix Z), only 35 of the 38 (84.2%) respondents who were couples counsellors identified at least one correct tenet. There were 92 (80.7%) correctly identified tenets made by these psychoanalytically oriented respondents. On one hand, this group illustrated their understanding as well as the congruence between what they *claimed* to

be their theoretical orientation (i.e. the psychoanalytic model) and their *demonstration* of their ability to describe the main tenets of this model. On the other hand, a surprising finding was that 3 of these respondents (almost 8%) did not identify even one tenet correctly. A similar pattern was found among the social workers' sample and the sample of other therapists. Only 26 of the 29 (89.7%) respondents who were social workers identified at least one correct tenet (Item #9b, p. 136). There were 70 (80.5%) correctly identified tenets made by these psychoanalytically oriented respondents. In this group, there were 3 respondents who claimed to be psychoanalytically oriented and could not identify even one tenet of this model. All 9 of the "other therapists" who were psychoanalytically oriented correctly identified a least one correct tenet. (Item #9b, p. 150). There were 24 (88.9%) correctly identified tenets made by these psychoanalytically oriented respondents.

It is concerning that there are practitioners who are treating couples and claiming to use this theoretical model for which they cannot correctly identify even one main tenet. Noteworthy is that these practitioners were given three opportunities to do so. This suggests that there are practitioners who are clearly practising and not using the model that they believe they are applying, or they are working within a particular theoretical framework with which they are not as familiar as they believe themselves to be; either of these scenarios is of serious concern, in terms of the implications for clinical practice and for those client couples being treated.

Noteworthy also is that only a small number of respondents who are couples counsellors (7.9%) selected "theoretical model" as their *most influential* source of data, indicating that most respondents attached little importance to theoretical model as a useful source of data (Table A4). Although a larger proportion of other therapists than social workers selected "theoretical model" as their most influential source of data, nevertheless this was still a very small number. The largest number of respondents (both among the samples of couples counsellors and social workers) chose "content" as their most influential source of data. (Table A4). (By way of contrast, the largest number of other therapists chose "couple interaction"). On the questionnaire,

"content" was further described as "your understanding of what the couple says in the vignette". Clearly, practitioners' selection of "content" as their most influential source of data illustrates the importance that they attach to *content* as opposed to *process*, and their emphasis and reliance on what mates *say* as opposed to *the underlying affect* that is manifesting itself in the more explicit modes of communication and behaviour.

Consideration and Use of Transference and Countertransference:

In view of the findings regarding knowledge and use of the psychoanalytic model, it is not surprising to find that practitioners are not aware of, do not acknowledge, or use the concepts of transference and countertransference to the extent that they could, in the understanding and treatment of couples. The very small number of research studies that have been done on the use of transference and countertransference have focused on work with individuals (for instance, Davanloo, 1978; Malan, 1976a, 1976b; Mann, 1973; Sifneos, 1966, 1967, 1972); Henry, Strupp, Schacht, & Gaston (1994), not couples. Findings of this study support results of previous research studies, in that not only did a very small proportion of respondents (3.5%) in the couples counsellors sample make at least one accurate identification of transference and/or countertransference as a key issue for the vignette couple (Item #11b, p. 313, Appendix Z), but very few respondents (4 = 0.6%) (Table A4, Appendix A) in the primary sample of couples counsellors even considered *personal reactions (subjective data)* that was further defined on this item as "your own feelings, what you know about yourself, etc.", as their most influential source of data (on Item #11c) (Table A4), when given an opportunity to assess the couple in the vignette. On Item #11c, respondents were asked to assess the couple, in terms of rank ordering three key issues for this couple and then selecting the sources of data that they used to determine their answer. While it may be encouraging that a larger number of couples counsellors (9.7%) selected subjective data as *one of their top three* most influential sources of data (Item #11c, p. 313, Appendix Z), demonstrating their consideration of their personal feelings and/or subjective

reactions as a useful foundation from which to design their assessment, nevertheless it was equally discouraging that this number was less than 10% of couples counsellors.

Of the few research studies that have been conducted focusing on the effectiveness of couples counselling, using psychodynamic approaches such as emotionally focused marital therapy and insight-oriented marital therapy (Greenberg & Johnson, 1986; Johnson & Greenberg, 1988; Johnson & Greenberg, 1989), none specifically examine or mention transference and countertransference. Nevertheless, the concepts of transference and countertransference have been found to be essential contributions to the interpersonal field of the therapeutic relationship (Tower, 1956; Racker, 1968; Langs, 1976; Epstein & Feiner, 1979; Mendelsohn, Bucci, & Chouhy, 1992). Theoretically, awareness of and analysis of transference and countertransference lead to insight and understanding. Although the potency of transference and countertransference as therapeutic "tools" in their effectiveness within the therapeutic process to create and maintain understanding and insight have been examined and demonstrated in the few research studies that have been done in this area with the focus on individuals (Malan, 1963; Sifneos, 1966, 1967, 1972; Binstock, Semrad, & Bloom, 1967; Fried, Crits-Christoph, & Luborsky, 1992; Henry, Strupp, Schacht, & Gaston, 1994), not couple systems, nevertheless the majority of respondents in this study who *claim* to have and use an awareness of these concepts do not demonstrate application of this awareness when presented with an opportunity (on the vignette).

The findings of this study converge with findings from other studies (Luborsky, Crits-Christoph, Mintz, & Auerbach, 1968; Mendelsohn et al., 1992), in that only a very small number of couples counsellors in this study identified transference and/or countertransference as key issues, in terms of what was going on for the vignette couple (Item #11b, p. 313, Appendix Z). There were only 3.5% accurate identifications of transference and countertransference made by couples counsellors. Among social workers, only 3.2% accurate identifications of transference and countertransference were made. The majority of social workers *did not* make even one accurate identification of transference and countertransference as one of the key issues in their

assessment of the vignette couple. It is concerning that a consideration of transferential and countertransferential issues was not even a part of the diagnosis of social workers in assessing the vignette couple.

Other studies have found that, "transference and its interpretations are a crucial element in a treatment relationship" (Binstock, Semrad, & Bloom, 1967; Malan, 1976), frequently by explicating how a connection to figures from the past is impacting upon the present (Menninger, 1958; Mann, 1969). Findings in this study revealed how few practitioners who work with couples considered the significance and implications of transference and countertransference for the vignette couple, in their assessment and treatment of this couple. One female respondent, with her M.S.W. degree, who *did* identify both transference and countertransference as considerations in her assessment and treatment plan, wrote, "The husband has issues with control carried over from his past, probably with his father, that he is projecting onto the therapist". Another female respondent with a non-social work degree wrote, "Both husband and wife have issues from their past (childhood) and past relationships (childhood) that are being replayed in their marriage. Dr. Jones is feeling incompetent and helpless. Transference and countertransference need to be explored."

The majority of respondents indicated issues related to communication and/or behaviour as the key issues for the vignette couple. One female respondent with a non-social work degree wrote, "Communication – need to explore the way the couple talks to each other, how they think about their relationship", and "There are conflicting expectations and needs. Need to teach the couple how to negotiate more effectively." Another female respondent with her M.S.W. degree wrote, "Behaviour and communication patterns. Patterns: Wife nags and complains, husband withdraws and immerses himself in his work", and "The therapist is too passive and non-directive. The couple needs to be blocked from following the same patterns."

While several respondents did allude to the vignette couple having "expectations" and "needs" that are currently being "unmet", and commented on the partners experiencing feelings of

"sadness", as well as "disappointment", "anger", and "resentment", only a very small proportion of respondents considered these as issues related to transference important enough that they, as therapists, would further explore in order to discover the origins and explanations, reveal recurrent themes and patterns in the couple's present relationship, and then work toward helping the couple to resolve and then relearn healthier modes of relating. Additionally, while the majority of respondents mentioned the vignette therapist's incompetence in terms of what they perceived as "a sense of helplessness", "lack of direction", and "lack of control over the session", very few respondents identified countertransferential effects and the need for the vignette therapist to work with those in some capacity in order to better help himself and/or the couple in the therapeutic process. Noteworthy is the very small number of social workers (5.1%) and other therapists (2.5%) who gave "therapist-client interaction" consideration as a most influential source of data. Although it may not be evident whether respondents perceive therapist-client interaction as more of a content-oriented or a process-oriented function or both, or whether respondents include subjective reactions as well as more overt responses to be essential components of therapist-client interaction, it *is* clearly evident that respondents place little importance on the interaction that takes place between therapist and client/client couple, as demonstrated in this study.

Although the concepts of transference and countertransference may be viewed and used as efficacious therapeutic tools in the diagnosis, assessment, and treatment of couples, nevertheless these concepts are very rarely considered and employed, as supported by the findings of this study.

It is also important to note that although the majority of respondents in this study did *claim* to have an awareness of these concepts in their clinical practice, as indicated by their responses to Items #23 (Table A23), #24 (Table A24), #25 (Table A25), and #26 (Table A26), nevertheless when asked to *demonstrate* this awareness and acknowledgment by identifying key issues for the vignette couple, only a very small proportion of practitioners were able to do so.

Transferential and countertransferential transactional experiences have been referred to as primary analytic data (Tower, 1956; Racker, 1968) to move toward 'corrective emotional change' (Alexander & French, 1946). Yet, as outlined in Table A4, very few respondents (0.6%) in the sample of couples counsellors, demonstrated their consideration of *personal* or *subjective data* as their most influential source of data in treating the vignette couple, when given the opportunity. *Personal data (subjective data)* was further defined on this item (#11c) as "your own feelings, what you know about yourself, etc." As previously mentioned, not only did a very small number of respondents identify transference and countertransference (on Item #11b) as key issues for the couple in the vignette, but very few respondents used *subjective data* (in Item #11c) as their most influential source of data to determine their assessment of this couple, in terms of the three key issues. It is encouraging that a larger number of couples counsellors (9.7%) selected "personal data" (subjective data) as *one of their top three* Most Influential sources of data, demonstrating their consideration of their personal feelings and/or subjective reactions as a useful foundation from which to design their assessment. (Item #11c, p. 313, Appendix Z). The largest number of respondents chose "content" as their most influential source of data. (Table A4). On the questionnaire, "content" was further described as "your understanding of what the couple says in the vignette".

A major hypothesis for this study was that practitioners may not be aware of the application of the concepts of transference and countertransference as potentially efficacious therapeutic tools (in assessment and treatment) that may be used within this model. The results of this study support this hypothesis, in that very few respondents who are couples counsellors demonstrated an awareness of, an acknowledgment of, or a considered application of these concepts in treating couples (Item #11c), or in treating the couple in the vignette (Item #11b).

Clearly, as mentioned earlier, practitioners' selection of "content" as their most influential source of data illustrates the importance they attach to *content* as opposed to *process*, and their emphasis and reliance on what mates *say* as opposed to the *underlying affect* that is manifesting

itself in the more explicit modes of communication and behaviour. From a psychoanalytic perspective, this is cause for concern, especially when the focus on emotional processes and affect (i.e. transferential and countertransferential effects) has been shown to be an effective therapeutic intervention for clients, and practitioners are expected to be attuned to, and attentive to affective processes in the therapeutic context.

The Gap Between Theoretical Knowledge and Clinical/Practical Application:

There was a gap in respondents' knowledge of the concepts of transference and countertransference, and their demonstrated ability to apply these concepts, which is concerning. From a psychoanalytic perspective, which emphasizes the centrality of transference and countertransference and working with these concepts, this finding constitutes a serious deficiency. There was an incongruity between what respondents *claimed* they knew and did in their clinical practice, and that which they *demonstrated* when given an opportunity to clinically apply on the vignette that which they had previously claimed on related items on the questionnaire. Results of the crosstabulations performed in a contingency table (See Chapter 4, pp. 161 - 164) demonstrated that what respondents *claimed* on theoretical and conceptual-oriented items was incongruent with how they performed on their *demonstrated* ability through their responses to practical-oriented items.

Awareness of, acknowledgment of, and use of transference and countertransference are essential to the therapeutic process and to the practitioners who work in clinical practice, and yet, practitioners are not as aware of, do not acknowledge, and do not use these concepts to the extent that they could. This is consistent with findings of related research studies. (Sehl, 1998; Mendelsohn et al., 1992). The findings of this study support this issue of incongruity between theoretical knowledge and practical application in clinical practice. Although the majority of respondents who are couples counsellors (85.6%) selected one of the three accurate definitions of transference (Table A27) and the majority of couples counsellors (83.9%) selected one of the

three accurate definitions of countertransference (Table A28), suggesting that these respondents *knew* what these concepts were, nevertheless only a few respondents *considered* and *applied* these concepts in their assessment of the vignette couple. Among couples counsellors, there were only 3.5% accurate identifications made of transference and countertransference in assessing the vignette couple, and among other therapists there were only 4.7% accurate identifications made of transference and countertransference. As outlined in Tables A23 through A26 inclusive, although the majority of respondents did *claim* to have an awareness of and an acknowledgment of the concepts of transference and countertransference in their clinical practice (as indicated by their responses on Items #23, #24, #25, and #26), nevertheless when asked to *demonstrate* this awareness and acknowledgment by identifying key issues for the vignette couple (Item #11b), only a very small proportion of practitioners were able to do so. (p. 313, Appendix Z).

Depending on the difficulty of the practical application-oriented item (related to the vignette), between 20% to 60% of couples counsellors were consistent in their responses. Of greater interest is that of the remaining couples counsellors, the greatest majority (as great as 50 times in the case of difficult application-oriented items) of respondents overestimated their ability to recognize and effectively apply transference and countertransference on the vignette.

Variables Associated with Perception and Use of Transference and Countertransference, and of the Psychoanalytic Model:

Education/Academic Degree:

Academic degrees held and decade of graduation were found to be associated with the extent of respondents' awareness of, acknowledgment of, understanding of, attitude toward, and use of transference and countertransference, and of the psychoanalytic model. The type of academic degree held and the year of graduation appear to contribute to how well respondents scored on the key indices in this study. Across all of the key indices, couples counsellors with their M.S.W. degree, and other therapists, most of whom had an M.A. degree or a higher degree, scored

significantly higher than social workers with a B.S.W. degree only, suggesting that the academic training at the M.S.W. level, and an M.A. in a counselling-related field, better train graduates in the knowledge of the theoretical concepts of transference and countertransference, and the use of the psychoanalytic model. (See Tables 47 through 50 inclusive).

Interestingly, social workers with both a B.S.W. degree and an M.S.W. degree did not score as well as the social workers with only an M.S.W. degree, on many of the key indices. One could hypothesize that this is due to the two-year M.S.W. programme better preparing social workers for clinical practice from a psychoanalytic perspective. When B.S.W. graduates enter into an M.S.W. programme, they are admitted directly into the second year based on the (perhaps erroneous) assumption that they have obtained the necessary preliminary theoretical and conceptual knowledge and clinical/practical skills that are taught in the first year of the M.S.W. programme.

Couples counsellors with only a B.S.W. degree (i.e. no M.S.W. degree) scored the poorest on all of the key indices. This raises the question of whether undergraduate training and graduation with a B.S.W. degree are sufficient to prepare practitioners for clinical practice, especially practice with couples. These practitioners are being permitted to treat clients, although they only have a B.S.W. degree as their entry level into the practice of counselling. In the late 1960s and 1970s, a trend began where "many agencies that traditionally employed social work graduates of master's degree programmes as counselors and therapists replaced these practitioners with personnel without graduate training in social work, that is, with B.S.W.s" (Edward & Sanville, 1996, p. 14). Results from this study suggest that further training in the profession may be necessary, for the learning and integration of requisite theoretical knowledge and clinical practice skills.

Respondents who were other therapists scored as well as social workers with an M.S.W. degree (only), better than social workers with a B.S.W. degree (only), on all of the key indices, and better than social workers with a combination of B.S.W. and M.S.W. degrees. This suggests

that other therapists who do not have social work degrees but who do have a degree in a counselling-related field may be receiving some training in psychoanalytic practice and its application to work with couples.

Decade of Graduation:

In the 1960s, the psychoanalytic/psychodynamic models were the focus in social work schools. Later, in the 1970s and 1980s, the systemic and strategic models were the emphasis. Most practitioners who were trained and graduated in the 1970s and 1980s tend to have either the systemic or strategic orientation, whereas a greater number of practitioners who had been trained and graduated in the 1960s claimed and demonstrated more of a psychoanalytic orientation (both in theoretical and practical application) in this study. As displayed in Tables 4 and 5, those social workers who graduated with their M.S.W. degree in the 1960s and 1970s had the highest mean scores on the index of use/practical application. This suggests that M.S.W. graduates from these decades (i.e. the 1960s and the 1970s) are more likely to use the psychoanalytic model than those who graduated in more recent decades, and also that M.S.W. graduates from these decades are more likely than recent graduates to consider, and appropriately and accurately apply the concepts of transference and countertransference. However, one could also argue that these practitioners have been practising longer than respondents from any of the other decades, and therefore additional professional experience may also have had an influential effect.

Another interesting finding was that social workers who graduated in the 1960s identified transference and countertransference in the vignette three times as well as social workers in general, and those who graduated in the 1970s did almost twice as well. (Ch. 4, p. 137). This may be explained by what Edward and Sanville (1996) call a "move away from emphasizing the assessment and treatment of the individual client". (p. 15). Edward and Sanville state that in the 1980s, in schools of social work, "Casework was increasingly dropped as a method...more and more students were trained to become generalist – experts on everything from the treatment

of the individual to the organization of the community." (Ibid., p. 15). Training focused on treatment of the individual, and the emphasis on the psychoanalytic/psychodynamic orientation shifted toward different models where there was a consideration of the larger community and community-based practice as well as more systemic and strategic theoretical models.

All social workers with their M.S.W. degree demonstrated a positive attitude toward transference and countertransference (Table 4), and their acknowledgment of transference and countertransference was also quite high (Table 4). Awareness of, and understanding of the meaning of these concepts were moderate. In terms of their ability to apply these concepts to a clinical vignette, this was determined to be low for all social workers with their M.S.W. degree, even those practitioners who graduated in the 1970s. Findings of this study demonstrated that although social workers have an academic understanding of transference and countertransference, their ability to apply these concepts was very limited.

Also noteworthy is that while the sample of social workers who treat couples made only 3.2% accurate identifications of transference and countertransference, those who graduated with their M.S.W. degree in the 1960s had 9.0% accurate identifications of these concepts and those who graduated with their M.S.W. degree in the 1970s had 5.5% accurate identifications of these concepts. Those who graduated in the 1980s only attained 2.1% accurate identifications. This suggests that those social workers who were trained and graduated in the 1960s and 1970s were more able to identify transference and countertransference as key issues. Perhaps these practitioners had a more comprehensive education that included (better) training in the psychoanalytic model and the concepts of transference and countertransference.

Previous Employment as a Clinical Social Worker/Therapist/Counsellor:

Other therapists who had previous professional employment as a therapist scored higher than those who did not have previous professional employment, on the index of practical application/use. (Ch. 4, p. 140). This demonstrated that these practitioners were more likely to

use the psychoanalytic model, and transference and countertransference in their treatment of couples.

Findings demonstrated that the majority of other therapists in this study had previously been employed as a therapist/counsellor. (Table 29). It appears that having previous exposure to and experience in clinical practice impacts upon the practitioner's consideration of, and use of the psychoanalytic model, and of transference and countertransference. Perhaps the additional employment experience gives practitioners the opportunity to work in a variety of different settings where different theoretical models may be considered and applied when working with different types of client systems, or there has been the opportunity to work in a similar setting that translates into greater familiarity and comfort with a certain type of model that is being used and promoted.

Of interest to note is that respondents' previous employment experience as a therapist/ counsellor was found to be more significant than their current employment experience.

Previous Employment Setting:

Social workers whose previous employment setting was an academic/teaching one scored higher on the index of attitude toward transference and countertransference than other respondents with any other type of previous employment setting. (Table 10.) This suggests, perhaps, that practitioners who had previously worked within an academic realm had more knowledge about, training in, and understanding of these concepts. Nevertheless, although academics who were also currently engaged in clinical practice scored "High" on attitude, "Average" in terms of their awareness and understanding, "Average-High" on acknowledgment, and "Average" on the overall index, they scored (very) "Low" on use, as assessed by their demonstrated application of transference and countertransference (on the vignette). (Ch. 4, p. 169, Scoring on the Key Indices.) If those practitioners who are in the position of teaching have a positive attitude toward these concepts but do not clinically consider or use them, then it is

plausible that this gap between theory and practice is passed on to the students whom they teach. This may be a significant factor in understanding why the psychoanalytic paradigm and the concepts of transference and countertransference are not being taught or promoted in schools of social work, and when they are taught, it is not done by practitioners who are trained well or who believe in the efficacy of this model and these concepts. Noteworthy is that in a survey of clinical psychologists, done by Norcross, Prochaska, and Gallager (1987), the psychodynamic orientation had increased in use from 16% to 30% by clinical psychologists, in the 8 years prior to the survey being conducted. Findings of the study done by Norcross et al. demonstrated that the psychodynamic approach was found to be preferred by a larger number of clinical practitioners than academician-researchers. In comparing the scoring on the key indices by the sample of academics who engage in clinical practice with that of the primary sample of couples counsellors, in this study the academics scored only slightly higher on most of the key indices. (Ch. 4, p. 169)

Practitioners in private practice likely have more time and more independence over their own practice, which may translate into the use of a longer, more intensive therapy such as that characteristic of the psychodynamic/psychoanalytic model. This statement is supported by the findings of this study, in that social workers whose previous employment setting had been private practice scored higher on the index of understanding of transference and countertransference and on the overall index (Tables 11 and 12) than respondents whose previous employment setting had been another type of employment setting, suggesting that those practitioners who have had more independence and control over their (own) clinical practice also had the time to spend experiencing, working with, and further contemplating the use of transference and countertransference. Those practitioners who had previously worked in hospital-mental health settings scored higher on understanding and on the overall index than respondents who had previously worked in other types of previous employment settings (Tables 11 and 12), suggesting that perhaps there is more support for the psychoanalytic approach and the use of transference and countertransference in mental-health settings. Additionally, clinicians who prefer the

psychoanalytic approach in couples counselling may find that private practice and mental health settings are conducive to this type of therapeutic approach, since it is usually classified as a long-term therapy and clients are seen for longer periods of time within these types of settings.

Current Employment Setting:

Other therapists whose present employment setting was an academic/teaching one scored higher on the index of acknowledgment than those respondents who work in a hospital-medical setting. (Ch. 4, p. 141). Perhaps academics have a greater opportunity to be involved in their own professional development as well as in the teaching of others, and to a greater extent than most other practitioners do. Therefore, academics who are also engaged in clinical practice would have a greater knowledge about and understanding of the psychoanalytic model, and of transference and countertransference. Additionally, these practitioners would certainly have a greater opportunity to recognize the presence of these concepts than those practitioners who work in a hospital-medical setting where the tendency is to use short-term therapy and/or crisis intervention, both of which are not characteristic of the longer-term psychoanalytically oriented therapeutic model. The type of employment setting would certainly dictate the type of theoretical orientation that practitioners would use, depending on an agency's mandate, the policies and protocol of an organization, and the time factor involved.

Research studies done by Luborsky et al. (1971) and Marmor (1975) found that more practitioners who were psychologists and who were engaged in private practice settings selected the psychodynamic/psychoanalytic model as their treatment of choice in working with individuals. Findings in the study done by Norcross et al. (1987) demonstrated that, "the preference for the psychodynamic approach is found to be even larger among clinical practitioners, as opposed to academician-researchers". (Luborsky, 1971, p. xxii). As supported by these previous studies and this research study, the type of employment setting certainly impacts upon and informs the choice of theoretical model.

A respondent in this study with her M.S.W. degree, contacted this researcher to state that she would have preferred to select either the psychoanalytic model or the systems model to treat the vignette couple when asked about this on the questionnaire (Item #11a), however because "I work for the Children's Aid Society where the behavioural model is encouraged, I chose that one for the vignette couple, just as I routinely do at the agency." This respondent also stated, "The belief at our agency is that by focusing on and changing a client's behaviour, this will also change the client's way of thinking and also how he/she feels affectively. This is why our mandate seems to be behavioural-focused. Also, our work is very crisis-oriented and short-term. We don't usually have the time to use psychoanalytic theory or even the systems approach. We have a certain amount of time and/or a certain amount of sessions, and that pretty much determines what we do and how we do it."

Frequency with which Clinicians Counsel Couples:

The more frequently that social workers treat couples, the more likely these practitioners would be to use psychoanalytic theory, and the concepts of transference and countertransference. Findings of this study demonstrated that most social workers treat couples on a weekly basis (Table 14), which could be considered to be fairly frequently. These practitioners would have the opportunity to see the couple on a regular basis, have a working knowledge of the couple's history and functioning, and also be able to use the psychoanalytic model and transference and countertransference, which involves an intensive therapeutic process over an available extensive period of time.

Type of Treatment Format:

We already know that, "conjoint marital therapy is generally effective in alleviating marital distress and promoting marital satisfaction" (Gurman & Knistern, as cited in Johnson, 1991,

p. 177), and we also know that, "there seems to be some consensus that examining client process is the best strategy". (Jacobson, Johnson, & Greenberg, as cited in S. Johnson, 1991, p. 178). In terms of the best intervention to explore and examine both clients' functioning as individuals and as a couple, and to develop insight and understanding for both therapist and client couple, transference and countertransference are efficacious therapeutic tools that may be used in conjoint therapy with couples. Having both partners present in a session offers both the partners and the therapist the opportunity to observe, experience, and work with the dynamics of the couple as the partners interact within the therapeutic setting. As demonstrated in this study, the majority of social workers and other therapists in this study do treat couples in conjoint sessions. (Tables 15 and 37) A greater proportion (77.7%) of other therapists than (58.7%) social workers treat partners in conjoint sessions, suggesting that other therapists may receive further or better training regarding the most appropriate treatment formats for counselling couples. Findings in this study demonstrated that (greater) use of conjoint sessions was associated with a higher awareness of, acknowledgment of, understanding of, and use of transference and countertransference; these practitioners also scored higher on the overall index of transference and countertransference (Table 15). Not only did this study demonstrate that these practitioners are more likely to be aware of, and to acknowledge transference and countertransference, and to understand these concepts, as well as to perform well on the overall index, but additionally, these practitioners would be more likely to use the psychoanalytic model and the concepts of transference and countertransference in their clinical practice with couples.

While there is a multitude of literature available in the areas of psychoanalytic theory, psychoanalysis, and psychotherapy, there is a paucity of literature with a specific focus on couples counselling within the psychoanalytic model, and the use of transference and countertransference in the area of couples therapy. Several theorists (Heimann, 1950; Little, 1951, 1957; Tauber, 1954; Reich, 1960; Searles, 1975; Langs, 1978; Tansey & Burke, 1989) who have written extensively about these essential elements of the therapeutic relationship and the

therapeutic process within the psychoanalytic paradigm, focus more on the psyche of the individual within the counselling context, rather than on the psyche of the individual in-relation-to-other or others, as an interactional process, which is the case in couples counselling.

While some theorists have taken some preliminary steps toward the consideration of and implementation of transference and countertransference in the area of family therapy, again there is an even smaller number of theorists, clinicians, and researchers who are focusing on the use of transference and countertransference in conjoint couples counselling, and little literature available on this specific subject. While most practitioners who are couples counsellors in this study did *not* consider or apply the concepts of transference and countertransference in treating couples in general, or in working with the vignette couple (Items #11b and #11c), it is encouraging to note that the majority of couples counsellors *do* use conjoint sessions for counselling couples. Although conjoint sessions do offer the therapist the opportunity to observe, analyze, and interpret the dyadic dynamics as the partners "dance" together on both an intrapsychic and interpsychic level, it is important to note that this calls for a heightened awareness of, attunement to, and attentiveness to transferential and countertransferential effects on the part of the practitioner. If the practitioner lacks an awareness of, acknowledgment of, understanding of, positive attitude toward, and use of these concepts, then he/she as well as the mates will miss a valuable opportunity for insight, understanding, and corrective emotional change to occur on an intensive, affective level.

It is noteworthy that, in the course of this research study, a two-fold perspective of conjoint therapy was given to this researcher by two practitioners who treat couples. A colleague with her M.A. degree in a counselling-related field, stated, "I prefer to see couples conjointly. It gives me a better picture of who they are and how they relate together. It is right there for me to see and to intervene. It also gives me the chance to point things out to the partners as they are doing it that they might not otherwise be aware of, and we can work on understanding it and changing it right then and there." An opposing viewpoint was offered by another colleague with her M.S.W.

degree, who stated, "I prefer *not* to see couples together. The dynamics are so complex and the problems and issues are usually so complicated. It can be overwhelming, not just for them, but for me, and it can so easily get out of control. I prefer to see the partners individually, just because it is easier on me and keeps a better sense of control over the therapy session. Also, when things get out of control in conjoint sessions, and I either *don't know how to intervene* or *what to do*, or I just *cannot control the session* or *cannot protect either or both partners*, it makes me look really bad and I feel badly, too. I feel incompetent. This is why I try to see couples individually, and I tend to avoid conjoint sessions unless the couple really pushes me into it."

Length of Treatment (in Number of Sessions):

Findings demonstrated that there was a relationship between length of treatment (in number of sessions) and acknowledgment of and positive attitude toward transference and countertransference. Social workers who treated couples for a longer period of time (e.g. in 21 or more sessions) are more likely to acknowledge and have a positive attitude toward psychoanalytic approaches and the concepts of transference and countertransference, and to use them. (Ch. 4, pp. 130-131). Similarly, for other therapists who treated couples for a longer period of time (e.g. in 21 or more sessions), findings showed that the longer the treatment these practitioners employ in treating couples, the more likely they are to use the psychoanalytic model and the concepts of transference and countertransference. (Ch. 4, p. 146).

While these findings are encouraging, the majority of respondents do *not* use this type of length of treatment for couples. The majority of couples counsellors (both social workers and other therapists) use 1 - 10 sessions to treat couples (Table Z15, Appendix Z), and this may be considered short-term or brief therapy. Perhaps use of fewer sessions or therapy that is short-term in nature is indicative of the employment setting in which the practitioner practises or the mandate of a particular agency, or perhaps the use of brief therapy is dictated as a function of time or rather, a lack of time. Regardless, treatment of a couple over a longer period of time does

offer both therapist and couple the opportunity for a more intensive therapeutic process to take place; one in which transferential and countertransferential effects may be explored and given new understanding and meaning through the examination of unconscious and conscious functioning.

Peer Supervision:

Social work practitioners who received peer supervision scored higher on the overall index than those practitioners who did not receive peer supervision. (Item #8c, Ch. 4, p. 132). Those respondents who had a greater number of hours of peer supervision/consultation were more likely to acknowledge transference and countertransference. (Item #8c, Ch. 4, p. 132).

As Mendelsohn et al. (1992) found in their study on attitudes, therapists are not often comfortable disclosing their countertransferential reactions to themselves or to others, including peers and clients. Although literature emphasizes the usefulness of self-awareness on the part of the practitioner as well as the usefulness of self-disclosure in therapy, this issue is not one upon which all practitioners unanimously agree. There are opposing views regarding the usefulness of transference and countertransference in counselling clients, and an ongoing debate concerning the appropriate use of self-disclosure including countertransferential reactions. As findings in this study demonstrated, the majority of respondents who are couples counsellors were more able to identify the subjective reactions of the vignette therapist or the vignette couple rather than articulating *their own* subjective reactions although this is what they were asked to do. On Item #12a, the first half of this item was used to determine whether or not the respondent claimed to have any subjective reactions (e.g. thoughts and feelings) to the couple in the vignette. Respondents were initially asked on the first half of Item #12a, "Do you believe your subjective reactions would influence your response or interaction with this couple?" While the majority of respondents (85.1%) in the sample of couples counsellors indicated, "Yes" (Table A5), nevertheless when asked to *elaborate* on the second half of this question, they were unable to do

so. Only the minority of respondents (40.0%) were able to accurately describe *affect* and to articulate in what ways their subjective feelings would impact upon their response or interaction therapeutically and/or interpersonally. (Table A6). The majority of couples counsellors described their perception(s) or observation(s). Similar patterns were observed in the samples of social workers and other therapists (Table A5), where both the majority of social workers (84.3%) and other therapists (88.4%) described their perception(s) or observation(s), and the minority in both of these samples (i.e. 38.4% social workers and 46.7% other therapists) accurately described affect and were able to articulate in what ways their subjective feelings would impact upon their response or interaction with the vignette couple.

Clearly, the majority of practitioners were unable to correctly express affect but rather commented on behaviour, cognitive issues, and observations or perceptions related to the couple in the vignette, illustrating that practitioners found it easier to respond to more *concrete* issues rather than *affective* ones. Several respondents who did address affective issues commented on them as related to the couple system as opposed to describing *their own* subjective reactions to the couple, which is what the respondent was asked to do on this item.

The following is an example of a correct response, demonstrating *the respondent's subjective reactions* to the vignette couple, which was given by one female social work practitioner, who wrote, "I felt very sorry for Crystal. I could feel her pain. I felt intimidated by David and yet, I could understand him feeling torn between his love for his wife and his work as a doctor".

The following is a typical example of an incorrect response that was written by another female social work practitioner: "Crystal seemed to be overly optimistic, probably unaware that her husband has been withdrawing for years. David seems angry and defensive; he may be generally dissatisfied with the relationship and his work, etc. Maybe he is having an affair. I think he is." It is evident that this respondent was describing the mates in the vignette and *their* thoughts and feelings, rather than *her own* subjective reactions, which the respondent was asked to do on this

item. Additionally, and also incorrect, were her comments that focused on her *cognitive* reactions as opposed to her *affective* ones.

On Item #16a, the respondent was asked to comment on any subjective reactions that he/she may have to the vignette therapist's approach and attitude to these clients/this client couple. The respondent was expected to describe any thoughts and feelings that he/she may have had regarding the therapist's approach and attitude, but responses on this item demonstrated that a large proportion of practitioners who are couples counsellors, both social workers and other therapists, were unable to accurately describe *their own* subjective reactions to the vignette therapist (Table A15), and therefore appeared to *not* have the awareness that they claimed in Item #12a (Table A5) when presented with the opportunity to demonstrate it or put it into practice (i.e. through application to the vignette).

On Item #16b, where the respondent was asked to comment on any subjective reactions that the vignette therapist may have had to these clients/this client couple, the respondent was expected to describe any thoughts and feelings that the vignette therapist may have experienced toward the clients/this client couple. In both groups of social workers and other therapists, a similar pattern was observed: the majority of respondents accurately identified and articulated the affective reactions of the vignette therapist in terms of his emotional reactions and thoughts. In comparing Item #16a where respondents were asked to comment on *their own* subjective reactions to the vignette therapist's approach and attitude to these clients/this couple, and Item #16b where respondents were asked to comment on the subjective reactions of *the therapist*, a greater number of respondents correctly articulated their response in Item #16b (Table A16) (by accurately describing the subjective reactions of the vignette therapist), and scored higher on this item than the previous one. Based on these statistics, we can see that practitioners find it easier to observe and comment on *someone else's reaction* other than *their own*. Respondents on these items clearly demonstrated more awareness of and attentiveness to the vignette therapist's subjective reactions (thoughts and feelings) than their own. This observation has implications for

practitioners, in terms of a need for increased self-awareness and attentiveness to their own subjective reactions within the therapeutic relationship.

In Sehl's (1998) study on erotic countertransference, findings showed that the frequency of discussing countertransferential issues during supervision was both significantly and moderately associated with utilizing countertransferential material to advance treatment objectives. However, Sehl also pointed out that most practitioners are not comfortable discussing their sexual feelings or under-report as a result of this sensitive type of conduct, and he concluded that, "training with respect to transferential and countertransferential sexual feelings should be increased in social work training and post-master's training." (p. 51). While Sehl's study focused on sexual feelings and erotic countertransference, a parallel can be drawn to the results of this study where the more peer supervision a social work practitioner received was associated with his/her being more likely to acknowledge transference and countertransference in working with couples.

It appears that practitioners are more comfortable sharing their subjective reactions and affective responses with their peers, as demonstrated by the fact that clinical supervision did not prove to be significant. A possible reason for the significance of peer supervision as opposed to clinical supervision is the lack of any type of repercussion. In any employment setting where clinical supervision is available, there is usually a senior practitioner who acts in a senior or advisory capacity or takes on an administrative role. There is the realistic issue of evaluation for the social work practitioner, and the fear of discomfort, embarrassment, or some type of reprisal, perhaps in the form of non-advancement in the work setting or termination of employment. Sharing with peers is less confrontational and less threatening; it is a more comfortable arena in which acceptance and understanding without judgment is more assured.

Results of this study suggest that peer support and/or peer consultation offers both support and ongoing learning to the practitioner who treats couples.

Comparison of Social Workers, Other Therapists, Academics, and Psychoanalytically Oriented Practitioners, on Key Indices:

Overall, social work practitioners scored "Average" in terms of their awareness and understanding, relatively "Average-High" on acknowledgment and attitude, and "Average" on the overall index. This group's score was rated (very) "Low" on use, which is their demonstrated application of transference and countertransference (on the vignette). (Table 26). The scores for the other therapists were very similar. (Table 45)

Noteworthy is that in comparing the three types of social workers (i.e. those with their B.S.W. degree only, those with an M.S.W. degree only, and those who hold a combination of B.S.W. and M.S.W. degrees), practitioners with their M.S.W. degree only (i.e. and no B.S.W. degree) have the highest mean score on all of the key indices. (Tables 46 through 50). As previously discussed, this suggests that those practitioners who trained and graduated with their M.S.W. degree from a two-year M.S.W. programme have a more intense and comprehensive educational background that better prepares them in both the requisite theoretical knowledge and clinical skills for social work practice. Those practitioners with 2-year M.S.W. degrees may be more likely to receive some training in psychoanalytic theory than those who only train in a B.S.W. programme, or those who first train in a B.S.W. programme followed by a one-year M.S.W. programme.

Also noteworthy is that in comparing the group of other therapists with the three types of social workers (i.e. those with their B.S.W. degree only, those with an M.S.W. degree only, and those who hold a combination of B.S.W. and M.S.W. degrees), the other therapists scored as high as social workers with only their M.S.W. degree, on the indices of awareness of transference and countertransference, and use/practical application of the psychoanalytic model, transference, and countertransference. (Tables 46 through 50). This suggests that other therapists may be exposed to more instructors who have a psychoanalytic orientation or professional training courses that include psychoanalytic theory, than some social workers.

As previously stated, the scores attained by academics who are also engaged in clinical practice was a surprising and disappointing finding in that these respondents did not do any better than any other respondents. This finding supports the hypothesis that psychoanalytic theory is not being taught or promoted in schools of social work; as well, when it is being taught, the teachers of this theory do not appear to be well-trained in their approach. If those who are in the position of teaching others are either not well-trained theoretically or practically, or lack the awareness, acknowledgment, understanding, and use of psychoanalytic theory and transference and countertransference, then there is a great likelihood that this will be passed on to those whom they teach. Herein lies the explanation for the small number of practitioners in this study who considered and selected the psychoanalytic model in treating couples in general, and in treating the vignette couple.

High scores by the psychoanalytically oriented respondents was an encouraging finding, that demonstrates how a strong theoretical knowledge and clinical skills based on psychoanalytic theory contributed to their better performance on scoring on the key indices. This group scored higher on all of the key indices than all other respondents with different types of theoretical orientations. This suggests that respondents who are psychoanalytically oriented have a greater awareness of, acknowledgment of, understanding of, and a more positive attitude toward transference and countertransference, and would be more likely to apply these concepts as efficacious therapeutic tools appropriately and accurately in their treatment of couples. This group demonstrated a higher recognition of transference and countertransference on the vignette (Item #11b), than couples counsellors in general. These psychoanalytically oriented respondents were approximately four times more likely than couples counsellors in general, to identify transference and countertransference as key issues in their assessment. (Ch. 4, p. 172)

Predictors of Ability to Apply Psychoanalytic Theory, and the Concepts of Transference and Countertransference:

As demonstrated by the Linear Regression model (Ch. 4, pp. 164-167), several variables proved to be significant as predictors of couples counsellors' abilities to apply psychoanalytic theory and the concepts of transference and countertransference to the vignette. The higher the respondent's score on the vignette, the better his/her demonstrated ability to apply this model and these concepts appropriately and accurately. (Table 52)

The predictor that was the largest contributor to higher score for application on the vignette, was the perceived usefulness of the psychoanalytic model with the vignette couple (Item #11a). This suggests that those practitioners who considered the psychoanalytic model to be a useful model in the understanding and treatment of couples have a greater level of theoretical and practical knowledge concerning this model and the concepts of transference and countertransference, which translates into their higher scoring on application of this model and these concepts on the clinical vignette. Not having a two-year M.S.W. degree also proved to be a significant predictor, as did having a higher score of theoretical knowledge of transference and countertransference. As discussed earlier, having a two-year M.S.W. degree suggests a more intensive and comprehensive programme of theoretical knowledge and clinical skills in social work that, it appears, has translated into these respondents scoring higher on most of the indices than other respondents who held a B.S.W. degree only or those who held a combination of B.S.W. and M.S.W. degrees.

In terms of the attainment of a higher score on theoretical knowledge of psychoanalytic theory, and transference and countertransference being a good predictor of ability to apply this model and these concepts, clearly having a strong knowledge of the psychoanalytic theory and transference and countertransference would translate into the likelihood of appropriate and accurate application of this model and these concepts in actual practice.

Awareness of the respondent's own feelings when treating couples also proved to be a good predictor. Clearly, being aware of, being attuned to, and acknowledging of one's own countertransference as a therapist implies an inherent consideration and use of these countertransferential effects in practical application in treating couples.

The (greater the) use of conjoint therapy in treating couples was also a good predictor, in terms of a respondent attaining a higher score on the application of the concepts of transference and countertransference. As previously discussed, treating couples in conjoint sessions gives the practitioner the opportunity to observe, analyze, and interpret the dyadic dance specific to each couple as well as the dyadic dynamics at play. The triadic dynamics that occur when the practitioner joins "the dance" also offer insight into and explanations of past and present functioning, as well as understanding that can be extended to both couple and therapist. The dynamics that are in play on both a conscious and unconscious level, and which are manifesting themselves in current functioning are more explicit and easier to observe in the interactional transactions of the couple system with both partners present. Conjoint therapy offers the couples counsellor and the couple an invaluable opportunity to observe, participate, and effect positive change with all significant partners in the process present. Conjoint therapy also gives the practitioner not only the opportunity to more clearly observe the couple's functioning behaviourally and cognitively, but affectively as well, and to use the psychoanalytic model and the concepts of transference and countertransference to further explore, understand, and intervene with the couple system.

Limitations:

There were several limitations associated with this research study, which are outlined below, but none hindered the progress of this study nor prevented its completion.

This research study was limited by the self-selection of a mailed survey; only those potential respondents who were receptive to being participants in this study responded. While the

importance of this research topic and the interest generated by this study motivated respondents (as indicated by written comments that were included with their mailed back questionnaires), to encourage a higher response rate, an incentive gift and raffle draw were offered to potential respondents. An e-mail note was sent to all members of the O.A.S.W. and the O.A.M.F.T., advising them of this research study and inviting them to participate. Only those members for whom e-mail addresses were available could be contacted, and some e-correspondence was returned as "Undeliverable" when the e-addresses were not accessible for a variety of reasons. As well, the larger population of O.C.S.W.S.S.W. members could not be contacted through this form of communication since their e-addresses were not made available to this researcher.

During the period of time that this study was being conducted and the surveys were being mailed out, the S.A.R.S. epidemic began and imposed a restriction on those potential respondents who were employed in hospitals and medical centres affected by this epidemic; in many cases, these practitioners could not gain access to their mail that had been sent to their (closed) offices due to the restricted access policy. Several surveys were mailed back to the researcher, stamped "Return to Sender" or "Undeliverable" with an explanatory note on the outside, stating this was due to S.A.R.S. Additionally, several respondents contacted the researcher to advise that they had received their questionnaire close to or, in some cases, after the due date for responding, once they had gained access to their place of employment. To compensate for this unforeseen circumstance, the due date for responding was extended; however, this did not guarantee a response from all those respondents affected by this situation.

During the time period when questionnaires were being reviewed, completed and mailed back, this researcher was contacted by several directors of various agencies (e.g. Toronto C.A.S.) who advised that a large number of their employees had received questionnaires that were being kept "On Hold" at the director's request since their policy required a separate and formal proposal review process. This researcher followed up on similar requests that were made known to her, and did receive approval for this research study from these agencies and thus, the questionnaires

were forwarded on to their employees. Unfortunately, however, due to the time frame involved for this additional review process to occur, the potential respondents received their questionnaires later than most of the other respondents and had to be notified of the extended due date to allow them to complete and return their questionnaires. Since these individuals had a shorter time period to respond, this may have influenced their lower response rate. It is important to note that the response rate for this survey was already substantial, and therefore any additional mailed back questionnaires would not have measurably affected the results.

Another limitation of a study like this one is the use of a vignette rather than observation of an actual couple in a counselling session. It is difficult to ascertain how closely answers on the questionnaire reflect actual practice. It is possible that respondents would have been able to articulate more affective reactions in response to an actual couple than to the vignette. Secondly, only one vignette was constructed to test their knowledge of transference and countertransference. There may have been issues related to the vignette that need to be explored further. For example, a review of the vignette was performed by experts who initially found it "too easy" in terms of the observation and identification of transference and countertransference; later, there was discussion about the possibility of the vignette being "too difficult" for respondents. After much discussion and review, the vignette was determined to be "fair" and evenly balanced, in terms of its design, wording, and the presence of transference and countertransference embedded within it for respondents to identify and on which to comment. Which features of the vignette make the identification of transference and countertransference easy or difficult, how to vary these features, etc., are all valid research questions that have not been investigated in this study.

In terms of the research instrument, there were several limitations. On Item #3c) where the respondent was asked to specify the majority of clients/patients whom he/she treated in his/her previous experience as a clinical social worker/therapist/counsellor, and on #6a) where he/she was asked to specify the majority of clients/patients whom he/she currently treats, an additional

sentence may have been added, advising respondents to "Choose the **one answer** that most accurately describes the majority of client/patients..." to ensure that respondents only selected the one most accurate response. On a number of questionnaires, respondents chose two or more responses. To resolve this issue, it was decided that where the respondent chose either "individuals" or "couples" in addition to another client/patient system, "individuals" or "couples" would be considered the majority of client/patient systems (previously or currently) treated; in the event that *both* "individuals" and "couples" were selected, "couples" would be determined to be the majority of client/patient systems (previously or currently) treated since practitioners who work with couples was the focus of this study.

Items #12b and #16a proved to be very difficult questions for respondents, as indicated by a noticeably low number of correct responses. On Item #12b (Table A8), the respondent was asked to describe how his/her subjective reactions would influence his/her response or interaction with the vignette couple. The majority of respondents articulated observations or perceptions rather than affective responses, and focused on content as opposed to process-oriented issues. Only a small number of respondents were able to articulate accurate responses on this item, demonstrating their awareness of their subjective reactions and/or how their subjective reactions would affect their response to or interaction with the vignette couple. Item #16a also appeared to be very challenging for respondents (Table A15), as indicated by the very low number of correct responses, especially in contrast to Item #16b where a much larger number of correct responses were given (Table A16). This suggests that it is easier for a practitioner to observe and comment on someone else's approach and attitude (i.e. those of the vignette therapist) rather than his/her own subjective reactions.

Items #27 and #28, which asked the respondent to choose the one accurate definition for transference and countertransference respectively, may have not been designed to be as challenging as they could have been. There were several (i.e. three) accurate responses among the choices, and the most accurate responses were longer in their phrasing than most of the

remaining options from which to choose. An often-made assumption is that the longer response is the correct one, which may help to explain why a large number of respondents selected one of the (three) correct responses even if they did not know it or were unsure, simply by "guessing correctly".

Implications for Clinical Practice:

If practitioners are not consciously aware of the natural phenomena of transference and countertransference in the therapeutic setting, nor of their ubiquitous nature, this is a critical clinical dilemma. Practitioners who are not even aware of the presence of these natural phenomena will not be able to appropriately recognize or manage them therapeutically. As well, these concepts will certainly be ignored as potentially efficacious tools to further the therapeutic action, or worse, they may be misused if not managed appropriately. Therapists need to be informed of the therapeutic tools available to them in order to be attentive to them, and to be educated in their technique; this can be provided at the academic level in their training as practitioners and advanced through proper supervision in the clinical practice arena.

As Sehl (1998) concluded in his study on erotic countertransference, "training with respect to transferential and countertransferential sexual feelings should be increased in social work training and post-master's training" (p. 51). While Sehl was referring to the need for further training for therapists regarding transferential and countertransferential *sexual* feelings, this same conclusion can be drawn for transferential and countertransferential feelings in general. Practitioners would certainly benefit from further education in this area, with the specific emphasis on awareness to, acknowledgment of, and attention to these concepts, as well as to the technique whereby these concepts can be used as efficacious therapeutic tools in the treatment of couples.

Sehl found in his study that, "almost 50% of the respondents indicated they had no post-master's training, and close to 20% indicated they had never been in supervision." (Ibid). Sehl concluded that, "Therefore, there is a need for professional state social work associations to

encourage social workers to get advanced training and to utilize supervision". (Ibid). This study found that only a very small minority of couples counsellors had post-master's training (Appendix Z, Item #2, p. 296), and in terms of supervision, the majority of couples counsellors who did receive supervision received it minimally. (Table Z17). Having peer supervision was indicated by the majority of respondents, and was proven to be a significant factor in scoring on the index of use/practical application, demonstrating the positive aspects of peer supervision. Based on the small number of hours per month of peer supervision (Appendix Z, Item #8c, p. 305), there is a substantial lack of peer supervision for practitioners.

Sehl also raised "a question as to how frequently educational efforts are approached within an atmosphere that invites freedom of expression". (Ibid). Others have addressed the difficulties or discomfort of self-disclosure (Rodolfa, 1994) and the low number of practitioners who seek consultation (Butler, 1975) in cases of sexual suggestion, harassment, or related issues. While the previously mentioned studies discussed the area of transference and countertransference as related to sexual thoughts and feelings, nonetheless while the subject is different, the themes are similar. It is important to ensure that practitioners feel comfortable seeking consultation to both resolve and learn from issues of transference and countertransference in the therapeutic relationship, and practitioners' employment settings as well as educational settings need to be conducive to the type of atmosphere where both students (in educational settings) and practitioners (in employment settings) can feel comfortable seeking advice and guidance, as well as support in these areas.

Education:

While the psychoanalytic/psychodynamic paradigm was taught and promoted in social work schools during the 1960s and 1970s, the trend in later years and currently, is a move away from this model in favour of a more systemic or eclectic one. In this research study, the majority of couples counsellors chose the systems model as their first model of choice in working with

couples in general (Item #9a), and as their first model of choice in treating the vignette couple (Item #11a). Only a very small number of practitioners selected the psychoanalytic model as their orientation, both in treating couples in general, and in working with the vignette couple; furthermore, the psychoanalytic model was the least popular choice among respondents.

Mendelsohn, Bucci, and Chouhy (1992), found that a practitioner's theoretical orientation influences his/her attitude toward the concepts of transference and countertransference. That which is taught as well as how it is taught is a key factor both in the knowledge base and attitudes of practitioners, and will also determine their theoretical orientation as well as the extent to which they use the various concepts within that theory.

If the psychoanalytic/psychodynamic model is not being taught in social work schools and other types of counselling programmes, then a gap certainly exists in the knowledge base and practice skills of these graduates. Practitioners need to have a broad frame of reference and a variety of theoretical models at hand in order to select the most appropriate model in which to understand and treat their couple client systems. If practitioners do not have a firm foundation in the form of a strong knowledge background in psychoanalytic/psychodynamic theory or a repertoire of clinical skills distinctive to this particular theory, or training in terms of when to call upon this model as a potent paradigm, then these practitioners are lacking a valuable method for both understanding and intervening in counselling couples.

Additionally, while only a small number of respondents indicated that they did not have an accurate understanding of the concepts of transference and countertransference (Tables A27 and A28), nevertheless this was an important statistic that revealed there are some practitioners who do have this gap in both their training and their practice. These practitioners would not be using these concepts, avoiding them entirely, or using them inappropriately, which could be detrimental to clients.

Another important finding revealed that practitioners who graduated with their M.S.W. degrees, those who have both their B.S.W. and M.S.W. degrees, and other therapists with their

M.A. degrees in a counselling-related field scored higher on various key indices than practitioners who have only their B.S.W. degree. The implications are clear. There are practitioners who graduate and practise with a first-level degree in the field of social work (i.e. a B.S.W. degree) who may not be given enough background and training for working with couples. This could raise serious questions and concerns regarding social work education, in terms of whether B.S.W. programmes need to incorporate additional theoretical, conceptual and clinical material into their curriculum, or whether a B.S.W. degree is sufficient preparation for counselling couples.

Future Research:

Further research in this area would serve to expand theoretical knowledge and clinical practice, through an increased understanding and implementation of enhanced self-awareness on the part of practitioners as well as insight into the role that their own self-awareness impacts upon the therapeutic context and can further therapeutic action. Further research should attempt to improve on some of the methodological limitations of this study. The vignette was an important and unique component of this study, which was designed by the researcher, and it was used to determine whether or not respondents were able to indicate identifications of transference and/or countertransference correctly. While the vignette was employed as a good indicator of respondents' identification and application of transference and countertransference, varying features of the vignette may be used to determine whether respondents are more aware or less aware of the psychoanalytic model, and the concepts of transference and countertransference, etc. As well, experimental manipulation of the vignette may be used to determine how a range of variables impacts upon practitioners' perceptions of the psychoanalytic model and the concepts of transference and countertransference. An outcome study may also be considered.

As Mendelsohn, Bucci, and Chouhy (1992) concluded, it is necessary to "compare analyst's reports of technique with their actual practice" (p. 384). While gaps have been found in the

theoretical knowledge and practical application of practitioners as a result of this study, the extent of these gaps could be further investigated through observation of actual practice. A videotape could be used to test practitioners' ability to perceive and identify the concepts of transference and countertransference in a simulated couple counselling session. A longitudinal study could be implemented to review practitioners' degree of self-awareness and the extent to which the awareness of their own subjective reactions and those of their client couples are associated with the outcome of treatment.

A longitudinal study would be useful to examine the effective application of transference and countertransference in couples counselling, with follow-up done to investigate this area of research from the therapists' perspective as well as that of the couple systems being counselled. The measurement, in terms of effectiveness, of the application of the psychoanalytic paradigm, as well as that of transference and countertransference, would be both informative and enlightening.

Final Thoughts and Concluding Comments:

This research is built on the premise that it is essential for practitioners who work with couples to be both informed about and attentive to the psychoanalytic model and to the concepts of transference and countertransference within this model, to enable them to determine how to best use this model and these concepts in their understanding and treatment of the complex client couple system. The increased awareness of transference and countertransference as theoretical concepts that can be viewed and applied in clinical practice as therapeutic tools to (1) assist both practitioner and client/client couple in the pivotal process of uncovering and discovering origins of dysfunction that were previously concealed, and then to (2) promote healthier and happier functioning, would be a welcome addition to both the theoretical and clinical realms of social work practice.

Overall, findings of this research study revealed that very few practitioners who do couples counselling consider and use the psychoanalytic model. As well, findings revealed that very few

social workers and other therapists who do couples counselling, consider and use the concepts of transference and countertransference in their clinical practice. There exists a gap in practitioners' theoretical knowledge and practical/clinical application, as demonstrated by the incongruity of what the majority of practitioners *claim* they do, and what they actually *do* in their clinical practice. Practitioners *claimed* an awareness of, acknowledgment of, understanding of, attitude toward, and use of the psychoanalytic model and the concepts of transference and countertransference on theoretical-oriented items that did not translate into *demonstrated* clinical application on practice-oriented items related to the vignette.

Although the counselling realm has, as its focus, the qualities of attentiveness, attunement, empathy, and sensitivity as integral and critical components, and clinicians are considered to be well-trained and highly skilled in these areas, this study has found significant gaps. Affective responses of both couples and the counsellors who treat them are key factors in the therapeutic process that need and deserve attention, as well as a "working through" process as therapeutically indicated. The caring and conscientious practitioner has a working knowledge, understanding, and sophisticated comfort level regarding his/her own feelings and those of his/her client/client couple, and how these subjective reactions impact upon responses or interactions, both interpersonally and therapeutically. Additionally, transference and countertransference need to be well understood and well managed in order to be beneficial components of the therapeutic process. Not only do practitioners need the training to be able to consider and use the appropriate and most helpful model for understanding and treating couples, but they also need a working knowledge of the inherent technique and of the therapeutic tools that can accomplish treatment objectives. Practitioners also need to be well-informed, in terms of how to appropriately and accurately use these concepts in their treatment of troubled couples especially since, from a psychoanalytic perspective, the focus on emotional processes, particularly those generated by transference and countertransference reactions, has been shown to be an effective therapeutic intervention for clients.

The lack of consideration and use of a model that may be used to better understand and treat couples and concepts that may be used as efficacious therapeutic tools, or a rejection of this model and these concepts, points to a deficiency in the areas of awareness, acknowledgment, understanding, and attitude on the part of practitioners who attempt to help troubled couples. Clearly, all clinicians working with couples, and the couples whom they treat, could benefit from the awareness of, understanding of, and use of transference and countertransference within the psychoanalytic model.

Appendix A

The Questionnaire: Respondents' Responses to Items as Reported through Frequencies

Table A1: Item #9a - first choice

Option	Couples Counsellors n = 621		Social Workers n = 505		Other Therapists n = 116	
	n	%	n	%	n	%
Systems	108	17.4	71	14.1	37	31.9
Cognitive Behavioural	105	16.9	96	19.0	9	7.8
Eclectic	98	15.8	71	14.1	22	19.0
Communication	73	11.8	64	12.7	9	7.8
Emotionally Focused	69	11.1	53	10.5	16	13.8
Psychoanalytic	38	6.1	29	5.7	9	7.8
Insight-Oriented	26	4.2	24	4.8	2	1.7
Cognitive	25	4.0	24	4.8	1	0.9
Behaviour	14	2.3	13	2.6	1	0.9
Social Learning	4	0.6	3	0.6	1	0.9
Role	3	0.5	3	0.6	0	0.0
Ecological	3	0.5	3	0.6	0	0.0
Not Sure	9	1.4	8	1.6	1	0.9
Other	46	7.4	38	7.5	8	6.9
	*missing data = 33		*missing data = 27		*missing data = 6	

Table A2: Item #10

Option	Couples Counsellors n = 627		Social Workers n = 513		Other Therapists n = 114	
	n	%	n	%	n	%
I definitely have a clear/specific idea of how to approach this case	170	27.1	129	25.1	41	36.0
I have a general idea of how to approach this case	359	57.3	302	58.9	57	50.0
I have some uncertainty in terms of how to approach this case	81	12.9	67	13.1	14	12.3
I have some difficulty in terms of how to approach this case	14	2.2	13	2.5	1	0.9
I have no idea how to approach this case	3	0.5	2	0.4	1	0.9
	*missing data = 27		*missing data = 19		*missing data = 8	

Table A3: Item #11a - first choice

Option	Couples Counsellors n = 630		Social Workers n = 512		Other Therapists n = 118	
	n	%	n	%	n	%
Systems	83	13.2	57	11.1	26	22.0
Cognitive Behavioural	80	12.7	71	13.9	9	7.6
Eclectic	75	11.9	60	11.7	15	12.7
Communication	76	12.1	65	12.7	11	9.3
Emotionally Focused	109	17.3	86	16.8	23	19.5
Psychoanalytic	43	6.8	33	6.4	10	8.5
Insight-Oriented	33	5.2	25	4.9	8	6.8
Cognitive	27	4.3	26	5.1	1	0.8
Behaviour	10	1.6	10	2.0	0	0.0
Social Learning	3	0.5	2	0.4	1	0.8
Role	8	1.3	7	1.4	1	0.8
Ecological	0	0.0	0	0.0	0	0.0
Not Sure	18	2.9	17	3.3	1	0.8
Other	65	10.3	53	10.4	12	10.2
	*missing data = 24		*missing data = 20		*missing data = 4	

Table A4: Item #11c - first choice

Option	Couples Counsellors n = 629		Social Workers n = 510		Other Therapists n = 119	
	n	%	n	%	n	%
Theoretical model/theoretical formulations **	50	7.9	37	7.3	13	10.9
Diagnostic theory	7	1.1	6	1.2	1	0.8
Treatment techniques	10	1.6	10	2.0	0	0.0
Content	259	41.2	217	42.5	42	35.3
Couple interaction	213	33.9	168	32.9	45	37.8
Therapist-client interaction **	29	4.6	26	5.1	3	2.5
Professional experience (your own)	56	8.9	42	8.2	14	11.8
Personal data (subjective data) **	4	0.6	4	0.8	0	0.0
Other	1	0.2	0	0.0	1	0.8
(** responses are the correct ones)		*missing data = 25		*missing data = 22		*missing data = 3

Table A5: Item #12a

Option	Couples Counsellors n = 650		Social Workers n = 529		Other Therapists n = 121	
	n	%	n	%	n	%
Yes	553	85.1	446	84.3	107	88.4
No	97	14.9	83	15.7	14	11.6
	*missing data = 4		*missing data = 3		*missing data = 1	

Table A6: Item #12a ...If yes

Option	Couples Counsellors n = 550		Social Workers n = 443		Other Therapists n = 107	
	n	%	n	%	n	%
Correct response	220	40.0	170	38.4	50	46.7
Incorrect response	330	60.0	273	61.6	57	53.3
	*missing data = 3		*missing data = 3		*missing data = 0	

Table A7: Item #12b

Option	Couples Counsellors n = 627		Social Workers n = 509		Other Therapists n = 118	
	n	%	n	%	n	%
Yes	493	78.6	391	76.8	102	86.4
No	134	21.4	118	23.2	16	13.6
	*missing data = 27		*missing data = 23		*missing data = 4	

Table A8: Item #12b ...If yes

Option	Couples Counsellors n = 485		Social Workers n = 385		Other Therapists n = 100	
	n	%	n	%	n	%
Correct response	79	16.3	66	17.1	13	13.0
Incorrect response	406	83.7	319	82.9	87	87.0
	*missing data = 8		*missing data = 6		*missing data = 2	

Table A9: Item #13

Option	Couples Counsellors n = 653		Social Workers n = 532		Other Therapists n = 121	
	n	%	n	%	n	%
Strongly agree	451	69.1	365	68.6	86	71.1
Agree	158	24.2	131	24.6	27	22.3
Somewhat agree	37	5.7	29	5.5	8	6.6
Somewhat disagree	5	0.8	5	0.9	0	0.0
Disagree	2	0.3	2	0.4	0	0.0
Strongly disagree	0	0.0	0	0.0	0	0.0
	*missing data = 1		*missing data = 0		*missing data = 1	

Table A10: Item #14

Option	Couples Counsellors n = 651		Social Workers n = 530		Other Therapists n = 121	
	n	%	n	%	n	%
Strongly agree	281	43.2	232	43.8	49	40.5
Agree	262	40.2	211	39.8	51	41.8
Somewhat agree	84	12.9	68	12.8	16	13.2
Somewhat disagree	13	2.0	9	1.7	4	3.3
Disagree	9	1.4	9	1.7	0	0.0
Strongly disagree	2	0.3	1	0.2	1	0.8
	*missing data = 3		*missing data = 2		*missing data = 1	

Table A11: Item #15a

Option	Couples Counsellors n = 646		Social Workers n = 529		Other Therapists n = 117	
	n	%	n	%	n	%
Very useful	81	12.5	66	12.5	15	12.8
Useful	196	30.3	158	29.9	38	32.5
A little useful	155	24.0	134	25.3	21	17.9
Not very useful	76	11.8	62	11.7	14	12.0
Not at all useful	11	1.7	10	1.9	1	0.9
I do not use this model	127	19.7	99	18.7	28	23.9
	*missing data = 8		*missing data = 3		*missing data = 5	

Table A12: Item #15a...If "I do not use this model" was chosen

Option	Couples Counsellors n = 120		Social Workers n = 92		Other Therapists n = 28	
	n	%	n	%	n	%
Because I do not find it relevant or useful	36	30.0	26	28.3	10	35.7
Because I am not familiar with this model	54	45.0	40	43.5	14	50.0
Because I am not comfortable with this model	30	25.0	26	28.3	4	14.3
	*missing data = 7		*missing data = 7		*missing data = 0	

Table A13: Item #15b

Option	Couples Counsellors n = 634		Social Workers n = 514		Other Therapists n = 120	
	n	%	n	%	n	%
Very useful	62	9.8	48	9.3	14	11.7
Useful	159	25.1	126	24.5	33	27.5
A little useful	147	23.2	126	24.5	21	17.5
Not very useful	115	18.1	97	18.9	18	15.0
Not at all useful	43	6.8	34	6.6	9	7.5
I do not use this model	108	17.0	83	16.1	25	20.8
	*missing data = 20		*missing data = 18		*missing data = 2	

Table A14: Item #15b...If "I do not use this model" was chosen

Option	Couples Counsellors n = 101		Social Workers n = 76		Other Therapists n = 25	
	n	%	n	%	n	%
Because I do not find it relevant or useful	22	21.8	16	21.1	6	24.0
Because I am not familiar with this model	57	56.4	41	53.9	16	64.0
Because I am not comfortable with this model	22	21.8	19	25.0	3	12.0
	*missing data = 7		*missing data = 7		*missing data = 0	

Table A15: Item #16a

	Couples Counsellors n = 595		Social Workers n = 482		Other Therapists n = 113	
	n	%	n	%	n	%
No. of responses	596	91.0	482	90.6	113	92.6
Missing data	58	9.0	50	9.4	9	7.4
Correct responses	82	13.8	66	13.7	16	14.2
Incorrect responses	513	86.2	416	86.3	97	85.8
	*missing data = 59		*missing data = 50		*missing data = 9	

Table A16: Item #16b

	Couples Counsellors n = 577		Social Workers n = 466		Other Therapists n = 111	
	n	%	n	%	n	%
Correct responses	350	60.7	281	60.3	69	62.2
Incorrect responses	227	39.3	185	39.7	42	37.8
	*missing data = 77		*missing data = 66		*missing data = 11	

Table A17: Item #17

Option	Couples Counsellors n = 635		Social Workers n = 516		Other Therapists n = 119	
	n	%	n	%	n	%
Affect	19	3.0	15	2.9	4	3.4
Behaviour	3	0.5	3	0.6	0	0.0
Cognition	1	0.2	1	0.2	0	0.0
Affect and behaviour	68	10.7	53	10.3	15	12.6
Affect and cognition	27	4.3	23	4.5	4	3.4
The combination of behaviour, affect, and cognition	195	30.7	167	32.4	28	23.5
The combination of behaviour, speech, and affect	44	6.9	33	6.4	11	9.2
The combination of behaviour, cognition, speech, and affect	258	40.6	210	40.7	48	40.3
I do not know	20	3.1	11	2.1	9	7.6
	*missing data = 19		*missing data = 16		*missing data = 3	

Table A18: Item #18

Option	Couples Counsellors n = 634		Social Workers n = 516		Other Therapists n = 118	
	n	%	n	%	n	%
Affect	21	3.3	16	3.1	5	4.2
Behaviour	1	0.2	0	0.0	1	0.8
Cognition	1	0.2	1	0.2	0	0.0
Affect and behaviour	50	7.9	37	7.2	13	11.0
Affect and cognition	33	5.2	28	5.4	5	4.2
The combination of behaviour, affect, and cognition	198	31.2	169	32.8	29	24.6
The combination of behaviour, speech, and affect	38	6.0	32	6.2	6	5.1
The combination of behaviour, cognition, speech, and affect	269	42.4	219	42.4	50	42.4
I do not know	23	3.6	14	2.7	9	7.6
	*missing data = 20		*missing data = 16		*missing data = 4	

Table A19: Item #19

Option	Couples Counsellors n = 643		Social Workers n = 525		Other Therapists n = 118	
	n	%	n	%	n	%
An obstacle or hindrance to therapy	35	5.4	30	5.7	5	4.2
A helpful component to therapy	208	32.3	173	33.0	35	29.7
Both (of the above)	369	57.4	301	57.3	68	57.6
Irrelevant to therapy	9	1.4	6	1.1	3	2.5
Something that I know very little about	12	1.9	8	1.5	4	3.4
No opinion	10	1.6	7	1.3	3	2.5
	*missing data = 11		*missing data = 7		*missing data = 4	

Table A20: Item #20

Option	Couples Counsellors n = 645		Social Workers n = 527		Other Therapists n = 118	
	n	%	n	%	n	%
An obstacle or hindrance to therapy	110	17.1	86	16.3	24	20.3
A helpful component to therapy	154	23.9	129	24.5	25	21.2
Both (of the above)	345	53.5	286	54.3	59	50.0
Irrelevant to therapy	10	1.6	7	1.3	3	2.5
Something that I know very little about	13	2.0	8	1.5	5	4.2
No opinion	13	2.0	11	2.1	2	1.7
	*missing data = 9		*missing data = 5		*missing data = 4	

Table A21: Item #21

Option	Couples Counsellors n = 641		Social Workers n = 523		Other Therapists n = 118	
	n	%	n	%	n	%
Only when working with individuals	10	1.6	9	1.7	1	0.8
Only when working with couples	1	0.2	1	0.2	0	0.0
When working with both (individuals and couples)	98	15.3	77	14.7	21	17.8
Only when working with families	0	0.0	0	0.0	0	0.0
Only when working with groups	1	0.2	1	0.2	0	0.0
When working with all of the above	501	78.2	415	79.3	86	72.9
Not relevant	6	0.9	4	0.8	2	1.7
Something I know very little about	24	3.7	16	3.1	8	6.8
	*missing data = 13		*missing data = 9		*missing data = 4	

Table A22: Item #22

Option	Couples Counsellors n = 645		Social Workers n = 527		Other Therapists n = 118	
	n	%	n	%	n	%
Only when working with individuals	11	1.7	10	1.9	1	0.8
Only when working with couples	0	0.0	0	0.0	0	0.0
When working with both (individuals and couples)	80	12.4	62	11.8	18	15.3
Only when working with groups	1	0.2	0	0.0	1	0.8
When working with all of the above	515	79.8	427	81.0	88	74.6
Not relevant	9	1.4	6	1.1	3	2.5
Something I know very little about	29	4.5	22	4.2	7	5.9
	*missing data = 9		*missing data = 5		*missing data = 4	

Table A23: Item #23

Option	Couples Counsellors n = 647		Social Workers n = 527		Other Therapists n = 120	
	n	%	n	%	n	%
Always	190	29.4	150	28.5	40	33.3
Often	247	38.2	209	39.7	38	31.7
Sometimes	166	25.7	135	25.6	31	25.8
Seldom	30	4.6	25	4.7	5	4.2
Never	7	1.1	4	0.8	3	2.5
Unsure what transference is	7	1.1	4	0.8	3	2.5
	*missing data = 7		*missing data = 5		*missing data = 2	

Table QA24: Item #24

Option	Couples Counsellors n = 648		Social Workers n = 528		Other Therapists n = 120	
	n	%	n	%	n	%
Always	212	32.7	173	32.8	39	32.5
Often	243	37.5	198	37.5	45	37.5
Sometimes	150	23.1	124	23.5	26	21.7
Seldom	26	4.0	22	4.2	4	3.3
Never	8	1.2	5	0.9	3	2.5
Unsure what countertransference is	9	1.4	6	1.1	3	2.5
	*missing data = 6		*missing data = 4		*missing data = 2	

Table A25: Item #25

Option	Couples Counsellors n = 642		Social Workers n = 526		Other Therapists n = 116	
	n	%	n	%	n	%
Found in all interpersonal relationships	329	51.2	268	51.0	61	52.6
Found in some interpersonal relationships	158	24.6	133	25.3	25	21.6
Only found in the therapeutic relationship	6	0.9	5	1.0	1	0.9
Sometimes found in the therapeutic relationship	81	12.6	64	12.2	17	14.7
Always present in the therapeutic relationship	47	7.3	41	7.8	6	5.2
Never present in the treatment situation	1	0.2	1	0.2	0	0.0
Unsure	20	3.1	14	2.7	6	5.2
	*missing data = 12		*missing data = 6		*missing data = 6	

Table A26: Item #26

Option	Couples Counsellors n = 641		Social Workers n = 526		Other Therapists n = 115	
	n	%	n	%	n	%
Found in all interpersonal relationships	279	43.5	222	42.2	57	49.6
Found in some interpersonal relationships	154	24.0	132	25.1	22	19.1
Only found in the therapeutic relationship	18	2.8	16	3.0	2	1.7
Sometimes found in the therapeutic relationship	111	17.3	91	17.3	20	17.4
Always present in the therapeutic relationship	49	7.6	43	8.2	6	5.2
Never present in the treatment situation	4	0.6	3	0.6	1	0.9
Unsure	26	4.1	19	3.6	7	6.1
	*missing data = 13		*missing data = 6		*missing data = 7	

Table A27: Item #27

Option	Couples Counsellors n = 643		Social Workers n = 524		Other Therapists n = 119	
	n	%	n	%	n	%
1. Attitudes, feelings, and behaviour toward one's family of origin	1	0.2	1	0.2	0	0.0
2. Attitudes, feelings, and behaviour belonging to a patient/client	3	0.5	3	0.6	0	0.0
3. Attitudes, feelings, and behaviour originating in a past significant relationship and being directed toward someone of significance in the present (mate, friend, employer, therapist) **	228	35.5	183	34.9	45	37.8
4. Attitudes, feelings, and behaviour belonging to a patient/client, originating in a past significant relationship and being directed toward the therapist, triggered by something in the therapist's personality or a reaction in the therapist's personality **	184	28.6	152	29.0	32	26.9
5. Attitudes, feelings, and behaviour belonging to a therapist	3	0.5	3	0.6	0	0.0
6. Attitudes, feelings, and behaviour belonging to the patient/client, originating in a past significant relationship and being directed toward the therapist **	138	21.5	111	21.2	27	22.7
7. Attitudes, feelings, and behaviour originating in the past and being replayed in the present	47	7.3	38	7.3	9	7.6
8. Attitudes, feelings, and behaviour originating from the patient's/client's transference and being directed by the therapist toward the patient as an unconscious reaction	12	1.9	11	2.1	1	0.8
9. Attitudes, feelings, and behaviour originating from the therapist's own past and in reaction to the patient's/client's transference, and being directed toward the patient/client as an unconscious reaction	11	1.7	11	2.1	0	0.0
10. I do not know enough about this concept	16	2.5	11	2.1	5	4.2
(** responses are the correct ones)	*missing data = 11		*missing data = 8		*missing data = 3	

Table A28: Item #28

Option	Couples Counsellors n = 638		Social Workers n = 520		Other Therapists n = 118	
	n	%	n	%	n	%
1. Attitudes, feelings, and behaviour toward one's family of origin	2	0.3	2	0.4	0	0.0
2. Attitudes, feelings, and behaviour originating in a past significant relationship and being directed toward someone of significance in the present (mate, friend, employer, therapist)	31	4.9	30	5.8	1	0.8
3. Attitudes, feelings, and behaviour belonging to a therapist	18	2.8	17	3.3	1	0.8
4. Attitudes, feelings, and behaviour originating in the past and being replayed in the present	17	2.7	14	2.7	3	2.5
5. Attitudes, feelings, and behaviour belonging to a therapist, induced by the patient/client and now being directed toward the patient/client as an unconscious reaction **	202	31.7	167	32.1	35	29.7
6. Attitudes, feelings, and behaviour originating in unresolved conflict from the therapist's own past, and in reaction to the patient's/client's transference, and being directed toward the patient/client as an unconscious reaction **	155	24.3	122	23.5	33	28.0
7. Attitudes, feelings, and behaviour belonging to the therapist, originating in a past significant relationship and being directed toward the patient/client **	178	27.9	139	26.7	39	33.1
8. Attitudes, feelings, and behaviour belonging to a patient/client	1	0.2	1	0.2	0	0.0
9. Attitudes, feelings, and behaviour belonging to the patient/client, originating in a past significant relationship and being directed toward the therapist	13	2.0	13	2.5	0	0.0
10. I do not know enough about this concept	21	3.3	15	2.9	6	5.1
(** responses are the correct ones)	*missing data = 16		*missing data = 12		*missing data = 4	

Table A29: Item #29

Option	Couples Counsellors n = 651		Social Workers n = 530		Other Therapists n = 121	
	n	%	n	%	n	%
Most of the time	353	54.2	286	54.0	67	55.4
Often	237	36.4	193	36.4	44	36.4
Sometimes	52	8.0	42	7.9	10	8.3
Occasionally	8	1.2	8	1.5	0	0.0
Seldom	1	0.2	1	0.2	0	0.0
I do not treat/see clients	0	0.0	0	0.0	0	0.0
	*missing data = 3		*missing data = 2		*missing data = 1	

Table A30: Item #30

Option	Couples Counsellors n = 650		Social Workers n = 529		Other Therapists n = 121	
	n	%	n	%	n	%
Most of the time	309	47.5	246	46.5	63	52.1
Often	268	41.2	219	41.4	49	40.5
Sometimes	59	9.1	51	9.6	8	6.6
Occasionally	7	1.1	7	1.3	0	0.0
Seldom	2	0.3	2	0.4	0	0.0
I do not treat couples	5	0.8	4	0.8	1	0.8
	*missing data = 4		*missing data = 3		*missing data = 1	

Table A31: Item #31

Option	Couples Counsellors n = 649		Social Workers n = 529		Other Therapists n = 120	
	n	%	n	%	n	%
Most of the time	156	24.0	124	23.4	32	26.7
Often	242	37.3	205	38.8	37	30.8
Sometimes	168	25.9	135	25.5	33	27.5
Occasionally	46	7.1	34	6.4	12	10.0
Seldom	37	5.7	31	5.9	6	5.0
I do not treat/see clients	0	0.0	0	0.0	0	0.0
	*missing data = 5		*missing data = 3		*missing data = 2	

Table A32: Item #32

Option	Couples Counsellors n = 648		Social Workers n = 528		Other Therapists n = 120	
	n	%	n	%	n	%
Most of the time	137	21.1	109	20.6	28	23.3
Often	224	34.6	189	35.8	35	29.2
Sometimes	187	28.9	148	28.0	39	32.5
Occasionally	54	8.3	43	8.1	11	9.2
Seldom	40	6.2	34	6.4	6	5.0
I do not treat couples	6	0.9	5	0.9	1	0.8
	*missing data = 6		*missing data = 4		*missing data = 2	

Appendix B: Coding and Scoring

The following indices were all scored out of 10: Awareness, Acknowledgment, Understanding, Attitude, Overall Index, and Use.

Awareness of Transference and Countertransference:

This index was composed of the following 6 items: #12a, #14, #16a, #16b, #29, and #30. All of the items were weighted equally, except #12a and #16a that received double the weight of the other 4 items. These items received double the weight because they posed challenging questions, and therefore the score reflects the level of difficulty of these items.

Table B1: Scoring on Awareness of Transference and Countertransference

Item	Option	Value	Maximum Value
12a	Yes	1.25	
	No	0.00	
12a if yes	Correct	1.25	
	Incorrect	0.00	**2.50**
14	1	1.25	
	2	0.833	
	3	0.417	
	4 - 6	0.00	**1.25**
16a	Correct	2.50	
	Incorrect	0.00	**2.50**
16b	Correct	1.25	
	Incorrect	0.00	**1.25**
29	1	1.25	
	2	1.00	
	3	0.75	
	4	0.50	
	5	0.25	
	6	0.00	**1.25**
30	1	1.25	
	2	1.00	
	3	0.75	
	4	0.50	
	5	0.25	
	6	0.00	**1.25**
Total			**10.00**

Item #12a was comprised of two parts. The entire item, i.e. #12a, was divided into two parts of equal weight. On the first part of this question the respondent was asked to respond by selecting "Yes" or "No." A "Yes" response was scored 1/2 the total value of #12a (= 1.25). On the second part of this question where the respondent was asked to elaborate if he/she had selected "Yes" on the first part, a correct/accurate response was scored 1/2 the total value of this item (= 1.25). Since the response to this item was considered to be a demonstration of awareness, the respondent's *claim* of being aware, as indicated by a response of "Yes" on the first part, was given equal weight to his/her demonstrated ability on the second part. (The second part of this item was only considered and scored if the respondent had responded with "Yes" on the first part of the item.) This was an open-ended question where, in order to receive the score, *the respondent was expected to demonstrate his/her subjective reactions to the vignette couple.* If the description was indeed a correct/accurate subjective reaction, as opposed to perception(s) and/or observation(s), then the respondent received the score.

An example of an accurate response: "Thoughts about my own experiences working with a 'David' i.e., anxious, frustrated, ineffective, overwhelmed, empathy for Crystal – her possible feeling of hopelessness, some understanding of David's frustration in his impatience and sentiments that the therapy isn't working." (Female respondent with her M.S.W. degree, who graduated in 1999). This respondent very clearly described her own subjective reactions to the partners. Another example of an accurate response was: "Annoyance at immature roles both [partners] playing – dominance/submissiveness but also approaching therapist as parent who will present solutions. Uncertainty - Has therapist explained his role (They have had homework – Is he a teacher? – Does he impose authority/solution?) Empathy – The couple reminisces about [a] period of good attachment and present intent." (Female respondent with an M.S.W. degree, who graduated in 1992). This respondent was able to comment on her feelings toward the client/client couple as well as her own feelings of uncertainty.

An example of an inaccurate response: "David escalates quickly, possibly as a means of pushing away and avoiding the issues brought out." (Female respondent with an M.S.W. degree, who graduated in 1992). This response illustrates the respondent's tendency to comment on the client and the client's behaviour, rather than focusing on herself and her own *subjective* reactions). Another example was: "[They] seem to be talking different languages. David seems very angry." (Female respondent with an M.S.W. degree, who graduated 1974). This respondent commented on the communication of the couple as well as on the husband's anger, instead of describing her own thoughts and feelings.

Item #14 was scored based on gradations. If the respondent chose option 1, "Strongly agree", then he/she received the total score for this item (= 1.25); if he/she chose option 2, "Agree", then he/she received 2/3 score (= .833), and if he/she chose option 3, "Somewhat agree", he/she received 1/3 score (= .417).

Item #16a was an open-ended question. The respondent received the total score (= 2.50) if he/she demonstrated his/her awareness of his/her subjective reactions to the therapist's approach and attitude to the client/client couple in the vignette.

Item #16b was also an open-ended question. The respondent received the score (= 1.25) if he/she demonstrated his/her awareness of the therapist's subjective reactions to the client/client couple in the vignette.

Items #29 and #30 were scored based on gradations. Respondents who selected option 1, "Most of the time", received full score (= 1.25) on this item. Respondents who selected option 2, "Often", received 4/5 the total score (= 1.0) for this item; respondents who selected option 3, "Sometimes", received 3/5 the total score (= .75) for this item; those who selected option 4,

"Occasionally", received 2/5 the total score (= .50) for this item; those who selected option 5, "Seldom", received 1/5 the total score (= .25) for this item.

Acknowledgment of Transference and Countertransference:

This index was composed of the following 6 items: #21, #22, #23, #24, #31, and #32. All 6 items received equal weight.

Table B2: Scoring on Acknowledgment of Transference and Countertransference

Item	Option	Value	Maximum Value
21	6 1 - 5, 7 - 8	1.667 0.00	**1.667**
22	6 1 - 5, 7 - 8	1.667 0.00	**1.667**
23	1 2 - 6	1.667 0.00	**1.667**
24	1 2 - 6	1.667 0.00	**1.667**
31	1 - 2 3 - 4 5 - 6	1.667 0.833 0.00	**1.667**
32	1 - 2 3 - 4 5 - 6	1.667 0.833 0.00	**1.667**
Total			**10.00**

Items #21 and #22 were given full score (= 1.667) if the respondent chose option 6, "When working with all of the above", since this was determined to be the most accurate response. Any other option that was selected was scored 0.

Items #23 and #24 were given full score (= 1.667) if the respondent chose option 1, "Always". Any other option that was selected was scored 0.

Items #31 and #32 were given full score (= 1.667) if the respondent chose option 1, "Most of the time" or option 2, "Often"; he/she received 1/2 the total value (= .833) if he/she chose option 3, "Sometimes" or option 4, "Occasionally".

Understanding of Transference and Countertransference:

This index was composed of the following 7 items: #10, #17, #18, #25, #26, #27, and #28. All 7 items received the same weight.

Table B3: Scoring on Understanding of Transference and Countertransference

Item	Option	Value	Maximum Value
10	1 - 2	1.429	
	3 - 5	0.00	**1.429**
17	6	1.429	
	1 - 5, 7 - 9	0.00	**1.429**
18	6	1.429	
	1 - 5, 7 - 9	0.00	**1.429**
25	1	1.429	
	2 - 6	0.00	**1.429**
26	5	1.429	
	1 - 4, 6 - 7	0.00	**1.429**
27	3, 4, 6	1.429	
	1, 2, 5, 7 - 10	0.00	**1.429**
28	5 - 7	1.429	
	1 - 4, 6, 8 - 10	0.00	**1.429**
Total			**10.00**

Item #10 was given full score (= 1.429) if the respondent chose option 1, "I definitely have a clear/specific idea of how to approach this case" or option 2, "I have a general idea of how to approach this case". Any other option that was selected was scored 0.

While this item does not relate directly to transference and/or countertransference, it is a relevant question that includes an implicit expectation of how capable the respondent believes him/herself to be in terms of treating this couple would also determine his/she ability to understand how effective transference and countertransference could be within this therapeutic

relationship. This item was included in the Index of Understanding since it asks the respondent to indicate to what extent he/she believes he/she would be able to approach the treatment of this couple; the response, in terms of degree of certainty, would also indicate the respondent's understanding of transference and countertransference as potential efficacious therapeutic tools in treating this couple.

Items #17 and #18 were given full score (= 1.429) if the respondent chose option 6, "The combination of behaviour, affect, and cognition", since this was determined to be the most accurate response. Any other option that was selected was scored 0.

Item #25 was given full score (= 1.429) if the respondent chose option 1, "Found in all interpersonal relationships", since this was determined to be the most accurate response. Any other option that was selected was scored 0.

Item #26 was given full score (= 1.429) if the respondent chose option 5, "Always present in the therapeutic relationship", since this was determined to be the most accurate response. Any other option that was selected was scored 0.

Item #27 was given full score (= 1.429) if the respondent chose option 3, "attitudes, feelings, and behaviour originating in a past significant relationship and being directed toward someone of significance in the present (mate, friend, employer, therapist)", or option 4, "attitudes, feelings, and behaviour belonging to a patient/client, originating in a past significant relationship and being directed toward the therapist, triggered by something in the therapist's personality or a reaction in the therapist's personality", or option 6, " attitudes, feelings, and behaviour belonging to the patient/client, originating in a past significant relationship and being directed toward the therapist". Any other option that was selected was scored 0.

Item #28 was given full score (= 1.429) if the respondent chose option 5, "attitudes, feelings, and behaviour belonging to the therapist, induced by the patient/client and now being directed toward the patient/client as an unconscious reaction", or option 6, "attitudes, feelings, and behaviour originating in unresolved conflict from the therapist's own past, and in reaction to the patient's/client's transference, and being directed toward the patient/client as an unconscious reaction", or option 7, "attitudes, feelings, and behaviour belonging to the therapist, originating in a past significant relationship and being directed toward the patient/client". Any other option that was selected was scored 0.

Attitude toward the Psychoanalytic Model, and toward Transference and Countertransference:

This index was composed of the following 4 items: #13, #15a, #19, and #20. All 4 items received the same/equal weight.

Table B4: Scoring on Attitude toward Transference and Countertransference

Item	Option	Value	Maximum Value
13	1	2.50	
	2	1.667	
	3	0.833	
	4 - 6	0.00	**2.50**
15a	1	2.50	
	2	1.667	
	3	0.833	
	4 - 6	0.00	**2.50**
19	3	2.50	
	1 - 2	1.25	
	3 - 6	0.00	**2.50**
20	3	2.50	
	1 - 2	1.25	
	3 - 6	0.00	**2.50**
Total			**10.00**

Item #13 was scored based on gradations. If the respondent chose option 1, "Strongly agree", he/she received full score for this item (= 2.5). If he/she chose option 2, "Agree", he/she received 2/3 the full value of this item (= 1.667); if he/she chose option 3, "Somewhat agree", he/she received 1/3 the full value of this item (= 0.833).

Item #15a was scored based on gradations. If the respondent chose option 1, "Very useful", he/she received full score for this item (= 2.5). If he/she chose option 2, "Useful", he/she received 2/3 the full value of this item (= 1.667). If he/she chose option 3, "A little useful", he/she received 1/3 the full value of this item (= 0.833).

Items #19 and #20 were given full value (= 2.5) if the respondent chose option 3, "both (of the above)". His/her response was given 1/2 value (= 1.25) if he/she chose option 1, "an obstacle or hindrance to therapy" or option 2, "a helpful component to therapy". Any other option that was selected was scored 0.

Overall Index of Transference and Countertransference:

This index was the mean score of all of the above indices combined (i.e. Awareness, Acknowledgment, Understanding, and Attitude). All 4 of these indices received the same weight and value.

Use of the Psychoanalytic Model, and of Transference and Countertransference:

This index was composed of the following 7 items: #9a, #9b, #11a, #11b, #11c, #12b, and #15b. Items #9b, #11b, #11c, and #12b were weighted double the value of the remaining items (#9a, #11a, and #15b). These items received double the weight because they posed challenging questions, and therefore the score reflects the level of difficulty of these items.

Table B5: Scoring on Use of the Psychoanalytic Model, and of Transference and Countertransference

Item	Option	Value	Maximum Value
9a	5	0.909	
	1 - 4, 6 - 14	0.000	**0.909**
9b	Correct tenet	0.606	
	Correct tenet	0.606	
	Correct tenet	0.606	**1.818**
11a	5	0.909	
	1 - 4, 6 - 14	0.000	**0.909**
11b	Correct id.	0.606	
	Correct id.	0.606	
	Correct id.	0.606	**1.818**
11c	See Table B6		**1.818**
12b	Yes	0.606	
	No	0.000	
12b if yes	Correct	1.212	
	Incorrect	0.000	**1.818**
15b	1	0.909	
	2	0.606	
	3	0.303	**0.909**
Total			**10.00**

Item #9a was given full score (= 0.909) if the respondent chose option 5, the "Psychoanalytic/ Psychodynamic" model.

Item #9b was only considered for scoring if the respondent chose option 5 in item #9a (i.e. the "Psychoanalytic/Psychodynamic" model). Each of "the 3 main tenets or key concepts" was scored 1/3 the total value of this item (= 0.606) if it was one of the accurately identified tenets of the Psychoanalytic model (as found in the Dictionary of Psychoanalytic Terms and Concepts). (A total score of 1.818 could be attained if all 3 of the responses were deemed to be tenets of the Psychoanalytic model.)

Item #11a was given full score (= 0.909) if the respondent chose option 5, the "Psychoanalytic/ Psychodynamic" model.

Item #11b was an open-ended question. Each of the three options was scored 1/3 the total value of this item (= 0.606) if the respondent correctly identified and/or described either transference or countertransference while describing key issues in the vignette (for a total of 1.818 if all 3 of his/her responses were correct identifications of transference and/or countertransference). The answers were considered to be acceptable/accurate if the respondent's description could be reasonably interpreted as an accurate description of the characteristics (in the form of main tenets or key issues) that fit the generally accepted definitions of transference or countertransference, even if the terms themselves (i.e. transference and/or countertransference) were not explicitly mentioned.

Table B6: Item #11c - Details of Scoring (for Index of Use):

	If option 8 chosen: "personal data" (subjective data)	**If option 6 chosen: "therapist-client interaction"**	**If option 1 chosen: "theoretical model"**
First choice	**0.909**	0.606	0.303
Second choice	0.606	**0.606**	0.303
Third choice	0.303	0.303	**0.303**

The maximum score of 1.818 could be achieved by the respondent if he/she selected all of the choices bolded in Table B6, and in the sequence demonstrated there. This complex formula was devised to give appropriate credit to the respondent's selection of the best/most accurate responses, and to also acknowledge the best order of his/her selections. (i.e. If the respondent chose option 8 "personal data" (subjective data) as his/her first choice, option 6 ("therapist-client interaction") as his/her second choice, and option 1 ("theoretical model") as his/her third choice, then he/she received the highest possible score on this item.)

As outlined in Table B6, Item #11c was scored as follows: For the respondent's first choice, if he/she chose option 8, "personal data", then he/she scored the total value for this item (= 0.909); if he/she chose option 6, "therapist-client interaction", then he/she scored 1/3 the total value for

this item (= 0.606); if he/she chose option 1 "theoretical model", then he/she scored 1/6 the total value for this item (= 0.303). For the respondent's second choice, if he/she selected either option 8 or option 6, he/she scored 1/3 the total value of this item (= 0.606); if he/she chose option 1, he/she received 1/6 the total value for this item (= 0.303); for the respondent's third choice, if he/she had chosen either option 8, 6, or 1, then he/she received 1/6 total value for this item (= 0.303).

Item #12b was comprised of two parts. On the first part the respondent was asked to respond "Yes" or "No". A "Yes" response received 1/3 of the total value of this item (= 0.606). On the second part a correct response was scored 2/3 the total value of this item (= 1.212). The second part was only considered if the respondent had responded "Yes" to the first part. This was an open-ended question where, in order to receive the score, the respondent was expected to both demonstrate that he/she was aware of his/her subjective reactions (and thus recognized what a subjective reaction really was), and also how this (subjective reaction) would influence his/her response in a meaningful way (i.e. the response would be something more than a statement or an explanation of protocol or procedure/technique, but rather a statement or an explanation of how the respondent's subjective reaction(s) would impact therapeutically or impact in terms of his/her interaction with the clients/client couple). No part marks were given.

An example of an accurate response was: "Irritation at her helplessness would lead me to name and explore this with her as an issue connecting it back to family of origin experiences. I'd also use this as a clue for how her helplessness might impact him." (Female respondent with an M.S.W. degree, who graduated in 1998). This therapist was able to identify her own subjective reactions and articulate how she would use them in her intervention strategies with the clients/client couple. Another example of an accurate response was: "I would need to carefully monitor my own defensive feelings to the professional attack by the husband, but at the same time reflect to him that his need to attack me may be due to feeling vulnerable and defensive

himself." (Female respondent with an M.S.W. degree, who graduated in 1993). The respondent was able to identify and articulate her own defensive feelings, and indicate how she would use these feelings to reflect back to the vignette husband the possibility of his own underlying need to be defensive within the therapeutic relationship.

An example of an inaccurate response was: "I don't think we can ever be fully objective – not sure exactly how I would be influenced – possibly feel more empathy with wife because I am a woman but not sure – I don't do family counselling." (Female respondent with a B.S.W. degree, who graduated in 2002). The respondent does not articulate in what ways her subjective reactions would impact upon her interaction with this couple. Another example of an inaccurate response was: "Objectivity is a myth; [I] would either try to get the woman to speak up or the man to shut up and listen/engage in working on the relationship." (Female respondent with an M.S.W. degree, who graduated in 2002)

Item #15b was scored based on gradations. If the respondent chose option 1, "Very useful", he/she received full/total score for this item (= 0.909). If he/she chose option 2, "Useful", he/she received 2/3 the full value of this item (= 0.606); if he/she chose option 3, "A little useful", he/she received 1/3 the full value of this item (= 0.303).

Vignette Index:

This index was composed of the following 6 items: #11b, #11c, #12a, #12b, #16a, and #16b. Items #11b, #11c, #12b, and #16a were weighted double the value of the remaining items (#12a and #16b). These items received double the weight because they posed challenging questions, and therefore the score reflects the level of difficulty of these items. All of these items have been scored in exactly the same way as outlined above, for the "Scoring of the Indices" (Section 1) with the exception of #12a. This index was scored out of 30.

Table B7: Scoring on Vignette Index

Item	Option	Value	Maximum Value
11b	Correct identification	2.00	
	Correct identification	2.00	
	Correct identification	2.00	**6.00**
11c	See Table B8		**6.00**
12a	Yes	1.00	
	No	0.00	
12a if Yes	Correct	2.00	
	Incorrect	0.00	**3.00**
12b	Yes	2.00	
	No	0.00	
12b if Yes	Correct	4.00	
	Incorrect	0.00	**6.00**
16a	Correct	6.00	
	Incorrect	0.00	**6.00**
16b	Correct	3.00	
	Incorrect	0.00	**3.00**
Total			**30.00**

Item #11b was an open-ended question. Each of the three options was scored 1/3 the total value of this item (= 2.0) if the respondent correctly identified and/or described either transference or countertransference while describing key issues in the vignette. (The respondent could attain a total score of 6.0 if all 3 of his/her responses were correct identifications of transference and/or countertransference). The answers were considered to be acceptable/accurate, as outlined under "Use of the Psychoanalytic Model, and of Transference and Countertransference" on the previous two pages.

Table B8: Item #11c – Details of Scoring (for Vignette Index)

	If option 8 chosen "personal data" (subjective data)	If option 6 chosen "therapist-client interaction"	If option 1 chosen "theoretical model"
First choice	**3.0**	2.0	1.0
Second choice	2.0	**2.0**	1.0
Third choice	1.0	1.0	**1.0**

The maximum score of 6.0 could be attained by the respondent if he/she selected the choices bolded in Table B8, and in the sequence demonstrated there. See notes under "Use of the Psychoanalytic Model, and Transference and Countertransference for further details.

Item #12a was comprised of two parts. On the first part of this question the respondent was asked to respond by selecting "Yes" or "No." A "Yes" response was scored 1/3 the total value of this item (= 1.0). On the second part of this question where the respondent was asked to elaborate if he/she had selected "Yes" on the first part, a correct/accurate response was scored 2/3 the total value of this item (= 2.0). Since the response to this item is a demonstration of the respondent's *practical application* (on the vignette), additional weight was given to the second part of the item (as the first part is more related to the respondent's claim than their actual demonstrated ability). Further details regarding this item can be found under the index of "Awareness of Transference and Countertransference" (p. 232).

Item #12b was comprised of two parts. On the first part the respondent was asked to respond "Yes" or "No". A "Yes" response received 1/3 of the total value of this item (= 2.0). On the second part, a correct response was scored 2/3 the total value of this item (= 4.0). See notes regarding this item under "Use of the Psychoanalytic Model, and of Transference and Countertransference" for further details. (p. 241).

Item #16a was an open-ended question. The respondent received the score (= 6.0) if he/she demonstrated his/her awareness of his/her subjective reactions to the therapist's approach and attitude to the client/client couple in the vignette.

Item #16b was also an open-ended question. The respondent received the score (= 3.0) if he/she demonstrated his/her awareness of the therapist's subjective reactions to the client/client couple in the vignette.

Knowledge Index of Transference and Countertransference:

This index was composed of the following 10 items: #17, #18, #19, #20, #21, #22, #25, #26, #27, and #28. All 10 items received the same/equal weight. This index was scored out of 30.

Table B9: Scoring on Knowledge Index of Transference and Countertransference

Item	Option	Value	Maximum Value
17	6	3.00	
	1 - 5, 7 - 9	0.00	**3.00**
18	6	3.00	
	1 - 5, 7 - 9	0.00	**3.00**
19	3	3.00	
	1 - 2	1.50	
	3 - 6	0.00	**3.00**
20	3	3.00	
	1 - 2	1.50	
	3 - 6	0.00	**3.00**
21	6	3.00	
	1 - 5, 7 - 8	0.00	**3.00**
22	6	3.00	
	1 - 5, 7 - 8	0.00	**3.00**
25	1	3.00	
	2 - 6	0.00	**3.00**
26	5	3.00	
	1 - 4, 6 - 7	0.00	**3.00**
27	3, 4, 6	3.00	
	1, 2, 5, 7 - 10	0.00	**3.00**
28	5 - 7	3.00	
	1 - 4, 6, 8 - 10	0.00	**3.00**
Total			**30.00**

Items #17 and #18 were given full score (= 3.0) if the respondent chose option 6, "the combination of behaviour, affect, and cognition". Any other option that was selected was scored 0.

Item #25 was given full score (= 3.0) if the respondent chose option 1, "Found in all interpersonal relationships". Any other option that was selected was scored 0.

Item #26 was given full score (= 3.0) if the respondent chose option 5, "Always present in the therapeutic relationship". Any other option that was selected was scored 0.

Item #27 was given full score (= 3.0) if the respondent chose option 3, 4, or 6. Further details regarding this item can be found under the index of "Understanding of Transference and Countertransference" (p. 236).

Item #28 was given full score (= 3.0) if the respondent chose option 5, 6, or 7. Further details regarding this item can be found under the index of "Understanding of Transference and Countertransference" (p. 237).

Items #21 and #22 were given full score (= 3.0) if the respondent chose option 6, "when working with all of the above". Any other option that was selected was scored 0.

Items #19 and #20 were given full value (= 3.0) if the respondent chose option 3, "both (of the above)". His/her response was given 1/2 value (= 1.5) if he/she chose option 1, "an obstacle or hindrance to therapy" or option 2, "a helpful component to therapy". Any other option that was selected was scored 0.

Appendix C: A Summary of the Research Questions

A Summary of the Research Questions:

The major research questions that guided this research were answered by this study, and a brief summary follows, that is organized by each major research question.

1.) Do social work practitioners/therapists have an awareness of transference and countertransference?

A number of items (#12a, #14, #16a, #16b, #29, and #30) were used to tap into this major research question, in order to determine the proportion of practitioners who believe and claim to have an awareness of transference and countertransference. When social workers and other therapists who counsel couples were asked about their subjective reactions (e.g. thoughts and feelings) to the couple in the vignette (Item #12a), they did *claim* to have subjective reactions; however, when asked to elaborate, the majority of practitioners were not able to *demonstrate* this by accurately articulating their subjective reactions. The majority of practitioners described their observations and/or perceptions rather than their affective responses. Clearly, practitioners were unable to correctly express affect but were more readily able to comment on behaviour, cognitive issues, and observations or perceptions related to the couple in the vignette, illustrating that practitioners found it easier to respond to more concrete issues rather than process-oriented or affective ones. (Item #12b). Several respondents who did address affective issues commented on them within the couple system as opposed to *his/her own* subjective reactions to the couples, which is what the respondent was asked to do on this item, demonstrating that practitioners were more aware of others' subjective reactions than their own. Practitioners were better able to articulate the thoughts and feelings of the vignette therapist (Item #16a) than their own (Item #16b).

Respondents on these items clearly demonstrated more awareness of, and attentiveness to the vignette therapist's subjective reactions (i.e. thoughts and feelings) than their own. This observation has implications for practitioners, in terms of a need for increased self-awareness and attentiveness to their own subjective reactions within the therapeutic relationship.

2.) Do social work practitioners/therapists acknowledge transference and countertransference in their work with couples?

A number of items (#21, #22, #23, #24, #31, and #32) were used to tap into this major research question, in order to determine the proportion of practitioners who believe and claim to have an acknowledgment of transference and countertransference. Here, respondents were being asked in various ways to state whether or not they recognize or consider the concepts of transference and countertransference in their clinical work.

While it may be encouraging to note that the majority of practitioners *claimed* to consider the effects of transference when working with all client systems (Item #21), this claim did not translate into actual practice on vignette-related items where respondents had the opportunity to consider the effects of transference but did not. Again, while the responses of the majority of practitioners on this item were encouraging in terms of their indication that they *do* acknowledge their own subjective reactions, their *claimed* acknowledgment of countertransference (Item #22) did *not* translate into an *actual demonstrated consideration* of the effects of countertransference on vignette-based items. Respondents affirmed that they are more readily recognizing transferential effects within the therapeutic setting than countertransferential ones, which is a reflection of their degree of self-awareness. This affirmation was demonstrated in Items #12a and #12b, where although a small number of respondents responded to these items accurately/ correctly, nevertheless a larger proportion of respondents *were* able to accurately assess the affective reactions of the vignette couple and those of the vignette therapist rather than *their own*; this shows therapists have a greater sensitivity to their clients' subjective reactions than *their own*.

In summary, responses to these items demonstrate that a large proportion of couples counsellors, whether social workers or other therapists, *claim* to have an acknowledgment of their subjective reactions, but in general, the majority of practitioners do not acknowledge them most of the time. On several of the items where the respondent's opinion is asked for, there is a response extended which affirms a recognition of transference and countertransference; however, when the opportunity to demonstrate the recognition of these concepts is presented through vignette-related items, most of the respondents do not make their recognition and consideration of these concepts evident.

3.) Do social work practitioners/therapists have an understanding of these concepts?

Items #10, #17, #18, #25, #26, #27, and #28 were used to determine the proportion of respondents who had an accurate understanding of transference and countertransference.

In summary, most respondents did not demonstrate an accurate understanding of these concepts. On Items #17 and #18, for example, the majority of couples counsellors did *not* select the most accurate characterizations of transference and countertransference reactions respectively; in fact, the largest number of couples counsellors selected the responses that were the longest. Frequently, the selection of the longest response tends to mean "a guess" on the part of the respondent, who believes the longest option to be the most comprehensive and therefore the most accurate one.

While most respondents did select accurate definitions for transference (Item #27) and countertransference (Item #28), this may be because there were three accurate definitions presented for each concept. Additionally, the longest responses tended to be the most accurate ones; often, respondents will assume that the longer response is the most accurate one.

4.) What is the general attitude of social work practitioners and other therapists, regarding transference and countertransference?
Sub-Research Question: Do social work practitioners and other therapists view these concepts as useful in their clinical practice?

Items #13, #15a, #19, and #20 were used to determine the general attitudes of practitioners who counsel couples. As indicated on Item #15a, very few respondents (12.5% of couples counsellors), in both the samples of social workers and other therapists, selected the psychoanalytic/psychodynamic model as a "very useful" model in working with couples.

Although the majority of respondents indicated that they consider transference (Item #19) and countertransference (Item #20) as both obstacles or hindrances to therapy and as helpful components to therapy, nevertheless they did not consider nor use these concepts in their assessment of the vignette couple (Item #11b) and did not consider the use of subjective data as the most influential source of data in assessment (Item #11c).

Generally, both social workers and other therapists indicated a positive and receptive attitude toward the concepts of transference and countertransference, but this attitude was not demonstrated through consideration and application of these concepts in clinical practice (i.e. on the vignette or on vignette-related items).

5.) Do social work practitioners and other therapists apply these concepts appropriately to a clinical vignette?

Items #9a, #9b, #11a, #11b, #11c, #12b, and #15b were categorized under this question, to examine practitioners' application/use of the concepts of transference and countertransference on a clinical vignette. As demonstrated by this study, most respondents *did not* consider the psychoanalytic/psychodynamic model as their "most useful" model in treating couples (Item #9a), nor in treating the vignette couple (Item #11a). Additionally, the majority of social workers and therapists did not consider nor apply the concepts of transference and countertransference in their assessment of the vignette couple (Item #11b), nor did the majority of social workers and

other therapists consider subjective data to be an important nor useful source of influential data in their assessment (Item #11c).

6a) Do practitioners consider the usefulness of the psychoanalytic paradigm as both a model of understanding and as a model of intervention in treating couples? Is this their model of choice or preference? Is the psychoanalytic model even a consideration when they contemplate various other theoretical frameworks?

6b) Is the object relations model (Fairbairn) applicable as a model of understanding and intervention in couples counselling, as applied by Scharff and Scharff?

Items #9a, #9b, #11a, #11b, #15a, and #15b were categorized under this question, to examine (a) how useful practitioners consider the psychoanalytic paradigm to be in treating couples, and (b) whether the object relations model is considered and applied by practitioners in treating couples? As a brief summary, the majority of social workers and other therapists *did not* select the psychoanalytic model in counselling couples in general (Item #9a) nor in treating the vignette couple (Item #11a), when they were asked to select their choice of "useful" model and were given a variety of theoretical orientations from which to choose. Very few social workers and other therapists indicated their consideration or application of the object relations model in assessing the vignette couple (Item #11b).

Additionally, of the very few respondents who indicated their consideration of the psychoanalytic model as a useful model in treating couples (Item #9a), even fewer of these respondents identified any concepts from the object relations model which is a psychoanalytic, as key tenets (Item #9b).

Although a larger number of other therapists (32.5%) than social workers (29.9%) indicated that they considered the psychoanalytic paradigm as a "useful" model in treating couples, and a larger number of other therapists (27.5%) than social workers (24.5%) indicated that they considered this model as "useful" in treating the vignette couple, only a very small proportion of practitioners in both samples considered this model to be "very useful". It is concerning that of the 19.7% couples counsellors who indicated that they "do not use this model" when asked about

treating couples in general (Item #15a), 45.0% selected "Because I am not familiar with this model" by way of explanation. Of the 17.0% couples counsellors who indicated that they "do not use this model" when asked about its usefulness with the vignette couple (Item #15b), 56.4% selected "Because I am not familiar with this model". It is concerning that there are couples counsellors practising who are not choosing to use a helpful model for understanding and treating couples because they are not "familiar" with this theoretical orientation. This deficiency suggests a lack in training or in practical experience.

7) Do practitioners identify the presence of transference and countertransference within the case vignette, and if so, how would they use these as therapeutic tools? Would they view them as therapeutic tools that can be efficacious in the intervention/treatment of this specific couple?

Items #11b, #11c, #33, and #34 were used to determine the proportion of practitioners who identify transference and countertransference as key issues for the vignette couple, and also as therapeutic tools that can be useful in the intervention/treatment of this couple. Findings of this study revealed that very few practitioners who counsel couples identified these concepts, neither as key issues (#11b) nor as concepts that may be used as therapeutic tools (#11c). Clearly, findings demonstrated that couples counsellors, whether social workers or other therapists, place little importance on subjective data, as an influential source of data in the diagnosis and treatment of couples to facilitate the therapist nor to facilitate the couple in the therapeutic action.

8) Do gender, training or theoretical orientation, years of experience or use of supervision affect awareness, understanding, attitudes, and appropriate application of transference and countertransference?

Items #1 through #8 inclusive were designed to examine the potential significance and implications of demographic data. The demographic data provides a framework within which practitioners practise, and a foundation upon which the practitioner's knowledge base, skills, attitude, understanding and clinical application are predicated.

Several variables (e.g. theoretical orientation, treatment format, etc.) proved to be significant, and have been outlined in detail at the beginning of this discussion. In summary, there *are* variables that play an important role in how practitioners treat couples in that these variables inform their practice. One example, as highlighted in this study, is the theoretical orientation of practitioners. Findings in this study revealed that while very few respondents selected the psychoanalytic model as their theoretical orientation, nevertheless those who did indicate that they were psychoanalytically oriented scored the highest on all of the key indices, and also demonstrated a more accurate application of the psychoanalytic model, and the concepts of transference and countertransference.

Appendix D: Cover Letter/Letter of Information (General)

Heidi B. Gottlieb, M.S.W., RSW
Doctoral Candidate
Faculty of Social Work
Wilfrid Laurier University
E-Mail: hbg60@hotmail.com

March 31st, 2003

Dear Social Worker/Therapist/Counsellor;

As part of my doctoral studies at Wilfrid Laurier University, Faculty of Social Work, I am studying attitudes of clinical social workers/therapists/counsellors toward clinical practice, and the use of various theoretical models in clinical practice. There is very little research that has been done in this area in Canada. Variables in this research study have been drawn from the existing literature in the field, and are designed to add to the body of knowledge in the theoretical realm as well as that of clinical practice and continued research in the field.

The enclosed questionnaire is designed to increase understanding of the attitudes of clinical social workers and other helping professionals toward various issues in clinical practice. I am also interested in knowing the attitudes of non-clinical social workers toward the issues covered in the questionnaire and would therefore appreciate participation from these individuals also.

This is an important research study which will contribute significantly to our profession. The Ontario Association for Marriage and Family Therapy has been kind enough to allow me to draw a sample from their mailing list. Additionally, a random sample has been drawn from the Ontario College of Social Workers and Social Service Workers. Some members of the Ontario Association of Social Workers have also been included since these individuals are members of either or both of the above mentioned professional organizations.

This research study has been approved by the Wilfrid Laurier University Research Ethics Board. For any inquiries regarding the ethical implications of this survey, please contact Dr. Bill Marr, Chair, University Research Ethics Board, Wilfrid Laurier University, (519) 884-0710, ext. 2468.

Participation in this research study is voluntary, confidential and anonymous. This is an important research study and your participation will be sincerely appreciated and contribute significantly to the findings. Should you choose not to return your questionnaire, after one follow-up telephone call and then one reminder telephone call, any record of your identity in the sample will be destroyed.

Should you choose to participate, I can assure you that your responses will be kept strictly confidential. All completed questionnaires are mailed directly to me, and they will be kept secure in a locked filing cabinet until the completion of this study at which time they will be destroyed. Your responses will be shared only in aggregate, anonymous and coded form.

The enclosed questionnaire is coded for use in one follow-up telephone call and a further reminder telephone call. After you send the completed questionnaire back, the coded cover page will be separated from your questionnaire and your completed response will be anonymous. Your code will be used for the mailing of your complimentary gift and for our incentive draws only, and then be destroyed. Your responses will be seen only by me, the researcher, and then anonymously by my research assistant who will do the data entry.

As this questionnaire is being sent to members of two professional associations in Ontario and you may be a member of both, you may receive duplicate questionnaires. They are both exactly the same. If you do receive **TWO** copies of the questionnaire, **please complete only one** but **return them both** so that you do not receive another follow-up and reminder telephone call. Please print **DUPLICATE** on the additional, uncompleted questionnaire.

To encourage your participation, we are offering complimentary gifts for all participants who have returned their completed questionnaire by April 28th. On the enclosed flyer, you will see samples of professional cards and personalized stationery. You may choose either. Please complete the enclosed form, specifying your choice and how you would like your name to appear on either the professional cards or the personalized stationery. This will be a lovely gift for you or for someone you know. This gift is absolutely free and will be mailed to you at no charge, to thank you for participating in this research study.

To encourage an earlier response date, we will be having an Early Bird Draw for all participants who have returned their completed questionnaires by April 23rd. The first name drawn will win **$150** and the second prize will be **$100. There will be a Bonus Early Bird Draw for $200 for all participants who return their completed questionnaire by April 16th.** After the draws and the mailing of complimentary gifts, all records of your identity will be destroyed. While the printer and printing staff will receive the names, addresses and telephone numbers of participants in order for the complimentary cards or stationery to be prepared, this information will be on the order form and kept completely separate from the completed questionnaire. As well, these order forms will be destroyed after the orders have been filled.

The enclosed questionnaire will take about 30 to 40 minutes to complete. Your response will provide significant information to this important research study. **Please complete and return the questionnaire by the date specified above, or earlier if you wish to participate in the Early Bird Draws.**

I believe that this study poses no risk to respondents and that the results will benefit all social workers/ therapists/counsellors by contributing to our knowledge and understanding in the areas of theory, clinical practice and ongoing research. While I believe that this study poses no risk to respondents, should a respondent have any questions or concerns regarding their experience in participating in this questionnaire, please feel free to contact me .

The Ontario Association of Social Workers and the Ontario Association for Marriage and Family Therapy will receive copies of the findings of this research. Also, the results of my research may appear in presentations and publications. In the event that quotations may be included in presentations and publications, I will ensure that participants cannot be identified from those quotations. If you would like to receive a summary of the findings of this research study and an outline of the results, please contact me at the phone number listed below or through my e-mail address. My Web Address will be given to you if/when this becomes available. I expect the results to be available by August, 2003. Should you have any questions or concerns about the enclosed questionnaire, please contact me at (905) 882-0566 or contact either Dr. Bob Gebotys or Dr. Ed Hanna, my Dissertation Committee Co-Chairpersons, at (519) 884-1970.

Thank you in advance for your cooperation and support by participating in the exploration of this important area of research.

Sincerely,

Heidi B. Gottlieb

Heidi B. Gottlieb, M.S.W., RSW
Doctoral Candidate
Faculty of Social Work
Wilfrid Laurier University

E-Mail: hbg60@hotmail.com

Appendix E: Cover Letter/Letter of Information (O.A.S.W.)

Heidi B. Gottlieb, M.S.W., RSW
Doctoral Candidate
Faculty of Social Work
Wilfrid Laurier University
E-Mail: hbg60@hotmail.com

March 31st, 2003

Dear Social Worker/Therapist/Counsellor;

As part of my doctoral studies at Wilfrid Laurier University, Faculty of Social Work, I am studying attitudes of clinical social workers/therapists/counsellors toward clinical practice, and the use of various theoretical models in clinical practice. There is very little research that has been done in this area in Canada. Variables in this research study have been drawn from the existing literature in the field, and are designed to add to the body of knowledge in the theoretical realm as well as that of clinical practice and continued research in the field.

The enclosed questionnaire is designed to increase understanding of the attitudes of clinical social workers and other helping professionals toward various issues in clinical practice, including general concepts and theoretical considerations as they relate to clinical practice. I am also interested in knowing the attitudes of non-clinical social workers toward the issues covered in the questionnaire and would therefore appreciate participation from these individuals also.

The Ontario Association of Social Workers and The Ontario Association for Marriage and Family Therapy believe that this is an important research study which will contribute significantly to our profession. Both associations have been kind enough to allow me to draw a sample from their mailing lists. Additionally, a random sample has been drawn from the Ontario College of Social Workers and Social Service Workers.

This research study has been approved by the Wilfrid Laurier University Research Ethics Board. For any inquiries regarding the ethical implications of this survey, please contact Dr. Bill Marr, Chair, University Research Ethics Board, Wilfrid Laurier University, (519) 884-0710, ext. 2468.

Participation in this research study is voluntary, confidential and anonymous. This is an important research study and your participation will be sincerely appreciated and contribute significantly to the findings. Should you choose not to return your questionnaire, after one follow-up telephone call and then one reminder telephone call, any record of your identity in the sample will be destroyed.

Should you choose to participate, I can assure you that your responses will be kept strictly confidential. All completed questionnaires are mailed directly to me, and they will be kept secure in a locked filing cabinet until the completion of this study at which time they will be destroyed. Your responses will be shared only in aggregate, anonymous and coded form.

The enclosed questionnaire is coded for use in one follow-up telephone call and a further reminder telephone call. After you send the completed questionnaire back, the coded cover page will be separated from your questionnaire and your completed response will be anonymous. Your code will be used for the mailing of your complimentary gift and for our incentive draws only, and then be destroyed. Your responses will be seen only by me, the researcher, and then anonymously by my research assistant who will do the data entry.

As this questionnaire is being sent to members of two professional associations in Ontario and you may be a member of both, you may receive duplicate questionnaires. They are both exactly the same. If you do receive **TWO** copies of the questionnaire, **please complete only one** but **return them both** so that you do not receive another follow-up and reminder telephone call. Please print **DUPLICATE** on the additional, uncompleted questionnaire.

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To encourage an earlier response date, we will be having an Early Bird Draw for all participants who have returned their completed questionnaires by April 23rd. The first name drawn will win **$150** and the second prize will be **$100**. **There will be a Bonus Early Bird Draw for $200 for all participants who return their completed questionnaire by April 16th.** After the draws and the mailing of complimentary gifts, all records of your identity will be destroyed. While the printer and printing staff will receive the names, addresses and telephone numbers of participants in order for the complimentary cards or stationery to be prepared, this information will be on the order form and kept completely separate from the completed questionnaire. As well, these order forms will be destroyed after the orders have been filled.

The enclosed questionnaire will take about 30 to 40 minutes to complete. Your response will provide significant information to this important research study. **Please complete and return the questionnaire by the date specified above, or earlier if you wish to participate in the Early Bird Draws.**

I believe that this study poses no risk to respondents and that the results will benefit all social workers/ therapists/counsellors by contributing to our knowledge and understanding in the areas of theory, clinical practice and ongoing research. While I believe that this study poses no risk to respondents, should a respondent have any questions or concerns regarding their experience in participating in this questionnaire, please feel free to contact me .

The Ontario Association of Social Workers and the Ontario Association for Marriage and Family Therapy will receive copies of the findings of this research. Also, the results of my research may appear in presentations and publications. In the event that quotations may be included in presentations and publications, I will ensure that participants cannot be identified from those quotations. If you would like to receive a summary of the findings of this research study and an outline of the results, please contact me at the phone number listed below or through my e-mail address. My Web Address will be given to you if/when this becomes available. I expect the results to be available by August, 2003. Should you have any questions or concerns about the enclosed questionnaire, please contact me at (905) 882-0566 or contact either Dr. Bob Gebotys or Dr. Ed Hanna, my Dissertation Committee Co-Chairpersons, at (519) 884-1970.

Thank you in advance for your cooperation and support by participating in the exploration of this important area of research.

Sincerely,

Heidi B. Gottlieb

Heidi B. Gottlieb, M.S.W., RSW
Doctoral Candidate
Faculty of Social Work
Wilfrid Laurier University

E-Mail: hbg60@hotmail.com

Appendix F: Cover Page

FREE GIFT

PLEASE LEAVE THIS COVER PAGE ATTACHED TO YOUR QUESTIONNAIRE. IT WILL BE REMOVED UPON RECEIPT SO THAT YOU WILL BE SENT YOUR COMPLIMENTARY GIFT (CHOICE OF PERSONALIZED PROFESSIONAL CARDS OR PERSONALIZED STATIONERY) AND ENTERED INTO THE EARLY BIRD DRAW(S).

PLEASE RETURN YOUR COMPLETED QUESTIONNAIRE BY APRIL 28th TO RECEIVE YOUR FREE GIFT.

EARLY BIRD DRAW

COMPLETED QUESTIONNAIRES RECEIVED BACK BY APRIL 23rd WILL ALSO BE ENTERED INTO AN EARLY BIRD DRAW FOR A FIRST PRIZE OF $150.00 AND A SECOND PRIZE OF $100.00

BONUS EARLY BIRD DRAW

IN ADDITION TO THE ABOVE, COMPLETED QUESTIONNAIRES RECEIVED BACK BY APRIL 16th WILL BE ENTERED INTO A BONUS EARLY BIRD DRAW FOR A PRIZE OF $200.00

PLEASE RETURN THIS QUESTIONNAIRE IN THE ENCLOSED POSTAGE-PAID SELF-ADDRESSED ENVELOPE.

THANK YOU FOR YOUR INTEREST AND PARTICIPATION IN THIS IMPORTANT RESEARCH STUDY.

Appendix G: Instruction Page

Ms. Heidi B. Gottlieb, Ph.D. Candidate,
Faculty of Social Work,
Wilfrid Laurier University,
Waterloo, Ontario
Doctoral Dissertation Survey
March 31st, 2003

A Questionnaire on Attitudes of Social Workers and
Other Helping Professionals Toward Clinical Practice

Please read the following questions carefully and respond to each by either circling the number beside the most accurate response or by filling in the blank space, depending on the specific instructions for each question.

Please write out your response to the questions which ask for a written response.

The first part of the questionnaire asks you some general questions, and the second part of the questionnaire includes specific questions which correspond directly to the enclosed case vignette.

Thank you very much for your participation in this important research study.

Appendix H: Research Instrument/Survey Questionnaire

Heidi B. Gottlieb, Ph.D. Candidate

A QUESTIONNAIRE ON ATTITUDES OF SOCIAL WORKERS AND OTHER HELPING PROFESSIONALS TOWARD CLINICAL PRACTICE

PLEASE PRINT YOUR RESPONSES:

Please circle the number beside the correct answer that most accurately describes you.

1. Gender:

   1 Male
   2 Female

2. Educational Background:

   Please circle the numbers beside as many answers as applicable.
   Please specify the degree(s) with which you graduated.

   1 B.S.W. (Baccalaureate Degree) Year of Graduation: _____
   2 M.S.W. (Master of Social Work Degree) Year of Graduation: _____

   If M.S.W., please specify M.S.W. in which area of specialization: (Please circle the number beside your area of specialization)

   1 Individuals, Family and Groups
   2 Community Practice/Community Organization
   3 Social Policy
   4 Administration/Management
   5 I did not specialize
   6 Other (Please specify:) _____

   3 M.A. (Masters Degree) Please specify below.

   If M.A., please specify M.A. in which area - e.g. M.A. in Pastoral Counselling, M.A. in Education, etc.:

   Masters in _____ Year of Graduation: _____

   Masters in _____ Year of Graduation: _____

   4 Ph.D. (Doctoral Degree): Please specify below.

   If Ph.D., please specify Ph.D. in which area - e.g. Ph.D. in Social Work, Ph.D. in Sociology, etc.:

   Ph.D. _____ Year of Graduation: _____

   Ph.D. _____ Year of Graduation: _____

   5 Other Formal Training/Degree/Diploma: Year of Graduation: _____

   Please specify: _____

   _____

3. a) Are you presently working as a clinical social worker/therapist/counsellor?

1 Yes 2 No

3. b) Have you previously worked as a clinical social worker/therapist/counsellor?

1 Yes 2 No

3. c) The majority of clients/patients whom I have treated in my previous experience as a clinical social worker/therapist/counsellor were:

1 individuals 2 couples 3 families 4 groups

5 other (Please specify below.)

If other, please specify: _____

_____

4. How many years have you practised in the capacity of clinical social worker/therapist/counsellor?

Approximately _____ years.

5. a) Please circle the number beside the response that most accurately describes your current workplace.

1 Private practice
2 Social agency setting
3 Family Service agency
4 Organizational setting (e.g. Ontario College of Social Workers and Social Service Workers)
5 Hospital Setting – Mental Health Unit (e.g. Dept. of Psychiatry)
6 Hospital Setting – Medical Unit
7 Correctional setting
8 School Setting (e.g. elementary, secondary, post-secondary)
9 Academic/Teaching (e.g. college or university level)
10 Not currently working
11 Other (Please specify below)

If Other, please specify: _____

_____

5. b) Have you <u>previously worked</u> in any of the above employment settings? Please put the corresponding number beside the one setting where you have spent the majority of your professional experience here (Use the number from the above list.): _____

(Please answer the following questions based on your current experience. If you are not currently working as a clinical social worker/therapist/counsellor, please go directly to top of Page 5/ Question #10.)

6. a) In terms of my clinical practice, the majority of clients/patients whom I currently treat are:

1 individuals 2 couples 3 families 4 groups

5 other (Please specify below.)

If other, please specify: _____

_____

6. b) In general, I currently counsel approximately _____ couples a year.

(If you have written "0" here, please go directly to # 8. a).

7. a) In general, I presently tend to see at least one couple for counselling:

1 two or more times per week
2 once per week
3 once every two weeks
4 once every three weeks
5 once every four weeks
6 once every 5 weeks to once every 16 weeks
7 never

7. b) In general, I presently tend to see/counsel/treat couples:

1 in conjoint sessions (as a couple together) 2 individually

3 equal combination of individual and conjoint counselling sessions

7. c) In general, the type of therapy that I currently use most often when working with couples is:

1 1 - 10 sessions
2 11 - 20 sessions
3 21 or more sessions
4 Not Sure

8. a) Do you currently have a clinical supervisor who supervises your clinical practice?

1 Yes 2 No

If "Yes", please answer # 8. b)

8. b) How many hours of clinical supervision do you generally receive per month?

1 0 hours per month
2 1 hour per month
3 2 - 3 hours per month
4 4 - 5 hours per month
5 6 or more hours per month
6 Other. Please specify: _____

8. c) Do you currently engage in peer supervision/consultation?

1 Yes 2 No

If "Yes", please indicate number of hours per month: _____

9. a) The type of theoretical model that I find useful when working with couples is:
(Please indicate by rank order from the list below, with the number or name, which three models you would find most useful.)

If you do not treat couples, please go directly to the top of Page 5/ Question #10.

Rank order - Most Useful: _____
- Second Most Useful: _____
- Third Most Useful: _____

1 Behavioural (e.g. Behaviour Modification) 2 Cognitive (e.g. Learning Model)

3 Cognitive Behavioural 4 Social Learning 5 Psychoanalytic/Psychodynamic

6 Emotionally Focused 7 Insight-Oriented 8 Systems 9 Communication

10 Role 11 Ecological 12 Eclectic (Please specify below.)

If "Eclectic", please specify: _____

_____

_____

_____

13 Other (Please specify below.)

Please Specify: _____

_____

_____

_____

14 Not Sure how to classify the type of theoretical model that I would use

9. b) What do you see as the three main tenets or key concepts that characterize the theoretical model that you ranked "Most Useful" in # 9 a) above ?

1.) _____

2.) _____

3.) _____

At this point, please read the enclosed vignette, and then answer Part II of this questionnaire, which follows.

II. This next section of the questionnaire corresponds specifically to the case vignette that accompanies it. Please read the enclosed case vignette carefully, prior to answering the following questions. These remaining questions relate to this vignette.

10. In terms of working with/helping the couple presented in this vignette:

1 I definitely have a clear/specific idea of how to approach this case
2 I have a general idea of how to approach this case
3 I have some uncertainty in terms of how to approach this case
4 I have some difficulties in terms of how to approach this case
5 I have no idea how to approach this case

11. a) Previously, you were asked about the theoretical models that you find most useful. Which theory/model would you specifically find most useful as a model of understanding and intervention/ treatment for this couple?
(Please indicate by rank order from the list below, with the number or name, which three models you would find most useful.)

Rank order - Most Useful: _____
- Second Most Useful: _____
- Third Most Useful: _____

1 Behavioural (e.g. Behaviour Modification) 2 Cognitive (e.g. Learning Model)

3 Cognitive Behavioural 4 Social Learning 5 Psychoanalytic/Psychodynamic

6 Emotionally Focused 7 Insight-Oriented 8 Systems 9 Communication

10 Role 11 Ecological 12 Eclectic (Please specify below.)

If "Eclectic", please specify: _____

_____

_____

_____

13 Other (Please specify below.)

Please Specify: _____

_____

_____

_____

14 Not Sure how to classify the type of theoretical model that I would use

11. b) What is your overall impression of what is going on with this couple?
Having read the attached vignette (case study), please list three key issues. Rank Order these in order of their importance, as you identify them.

1.) _____

_____

2.) _____

_____

3.) _____

_____

11. c) What sources of data did you use to determine the answer to #11 b) above? Please rank order from the list below, the data that was most influential, next most influential and third most influential.
(Please indicate by rank order from the list below, with the number or name, which three sources of data you would find most influential.)

Rank Order - Most influential source of data: _____
- Second most influential source of data: _____
- Third most influential source of data: _____

1 theoretical model/theoretical formulations
2 diagnostic theory
3 treatment techniques
4 content (Your understanding of what the couple says in the vignette)
5 couple interaction
6 therapist-client interaction
7 professional experience (your own)
8 personal data (subjective data) - i.e. your own feelings, what you know about yourself, etc.
9 other (Please specify below.)

If "other", please elaborate: _____

_____

_____

_____

12. a) Did you have any subjective reactions (e.g. thoughts and feelings) to the couple in the vignette?

1 Yes 2 No

If "Yes", what were your subjective reactions to this couple? (Please describe below:)

12. b) Do you believe that your subjective reactions would influence your response or interaction with this couple?

1 Yes 2 No

If "Yes", how would your subjective reactions influence your response or interaction with this couple?

13. I believe that non-verbal communication is as important as verbal communication within the couple system and within the therapeutic triad (between therapist and client couple):
(Please circle the number beside the answer that most accurately reflects your attitude or opinion, regarding this statement.)

1 Strongly agree
2 Agree
3 Somewhat agree
4 Somewhat disagree
5 Disagree
6 Strongly disagree

14. I pay as much attention to my own feelings and responses as I do to the client's/client couple's communications. (Please circle the number beside the answer that most accurately reflects your attitude or opinion regarding this statement.)

1 Strongly agree
2 Agree
3 Somewhat agree
4 Somewhat disagree
5 Disagree
6 Strongly disagree

15. a) In general, how useful do you believe the psychoanalytic/psychodynamic model is, in working with couples?

1 Very useful
2 Useful
3 A little useful
4 Not very useful
5 Not at all useful
6 I do not use this model when working with couples

If you have circled this response (#6 above), please continue by circling one or more of the following responses which are applicable:

1 Because I do not find it relevant nor useful
2 Because I am not familiar with this model
3 Because I am not comfortable with this model

15. b) How useful do you believe the psychoanalytic/psychodynamic model would be in working with **this** specific couple?

1 Very useful
2 Useful
3 A little useful
4 Not very useful
5 Not at all useful
6 I do not use this model when working with couples

If you have circled this response (#6 above), please continue by circling one or more of the following responses which are applicable:

1 Because I do not find it relevant nor useful
2 Because I am not familiar with this model
3 Because I am not comfortable with this model

16. a) Please comment on any subjective reactions that you may have to this therapist's approach and attitude to these clients/this couple.

16. b) Please comment on any subjective reactions that the therapist may have toward these clients/this couple.

17. Transference reactions can be characterized as:
(Choose the <u>one</u> most accurate response.)

1 affect 2 behaviour 3 cognition 4 affect and behaviour 5 affect and cognition

6 the combination of behaviour, affect and cognition 7 the combination of behaviour, speech and affect

8 the combination of behaviour, cognition, speech and affect 9 I do not know

18. Countertransference reactions can be characterized as:
(Choose the <u>one</u> most accurate response.)

1 affect 2 behaviour 3 cognition 4 affect and behaviour 5 affect and cognition

6 the combination of behaviour, affect and cognition 7 the combination of behaviour, speech and affect

8 the combination of behaviour, cognition, speech and affect 9 I do not know

19. I consider transference to be:

1 an obstacle or hindrance to therapy
2 a helpful component to therapy
3 both (of the above)
4 irrelevant to therapy
5 something that I know very little about
6 No opinion

20. I consider countertransference to be:

1 an obstacle or hindrance to therapy
2 a helpful component to therapy
3 both (of the above)
4 irrelevant to therapy
5 something that I know very little about
6 No opinion

21. I consider the effects of transference:

1 only when working with individuals
2 only when working with couples
3 when working with both (individuals and couples)
4 only when working with families
5 only when working with groups
6 when working with all of the above
7 not relevant
8 something I know very little about

22. I consider the effects of countertransference:

1 only when working with individuals
2 only when working with couples
3 when working with both (individuals and couples)
4 only when working with families
5 only when working with groups
6 when working with all of the above
7 not relevant
8 something I know very little about

23. I consider the effects of transference when working with clients:

1 Always
2 Often
3 Sometimes
4 Seldom
5 Never
6 Unsure what transference is

24. I consider the effects of countertransference when working with clients:

1 Always
2 Often
3 Sometimes
4 Seldom
5 Never
6 Unsure what countertransference is

25. I believe that transference is:
(Please circle the number beside the most accurate response.)

1 Found in all interpersonal relationships
2 Found in some interpersonal relationships
3 Only found in the therapeutic relationship
4 Sometimes found in the therapeutic relationship
5 Always present in the therapeutic relationship
6 Never present in the treatment situation
7 Unsure

26. I believe that countertransference is:
(Please circle the number beside the most accurate response.)

1 Found in all interpersonal relationships
2 Found in some interpersonal relationships
3 Only found in the therapeutic relationship
4 Sometimes found in the therapeutic relationship
5 Always present in the therapeutic relationship
6 Never present in the treatment situation
7 Unsure

27. Transference is often defined as:
(Among the following definitions, please choose the <u>one</u> definition that you feel is best.)

1 attitudes, feelings and behaviour toward one's family of origin

2 attitudes, feelings and behaviour belonging to a patient/client

3 attitudes, feelings and behaviour originating in a past significant relationship and being directed toward someone of significance in the present (mate, friend, employer, therapist)

4 attitudes, feelings and behaviour belonging to a patient/client, originating in a past significant relationship and being directed toward the therapist, triggered by something in the therapist's personality or a reaction in the therapist's personality

5 attitudes, feelings and behaviour belonging to a therapist

6 attitudes, feelings and behaviour belonging to the patient/client, originating in a past significant relationship and being directed toward the therapist

7 attitudes, feelings and behaviour originating in the past and being replayed in the present

8 attitudes, feelings and behaviour originating from the patient's/client's transference and being directed by the therapist toward the patient as an unconscious reaction

9 attitudes, feelings and behaviour originating from the therapist's own past, and in reaction to the patient's/client's transference, and being directed toward the patient/client as an unconscious reaction

10 I do not know enough about this concept

28. Countertransference is most often defined as:
(Among the following definitions, please choose the <u>one</u> definition that you feel is best.)

1 attitudes, feelings and behaviour toward one's family of origin

2 attitudes, feelings and behaviour originating in a past significant relationship and being directed toward someone of significance in the present (mate, friend, employer, therapist)

3 attitudes, feelings and behaviour belonging to a therapist

4 attitudes, feelings and behaviour originating in the past and being replayed in the present

5 attitudes, feelings and/or behaviour belonging to the therapist, induced by the patient/client and now being directed toward the patient/client as an unconscious reaction

6 attitudes, feelings and behaviour originating in unresolved conflict from the therapist's own past, and in reaction to the patient's/client's transference, and being directed toward the patient/client as an unconscious reaction

7 attitudes, feelings and behaviour belonging to the therapist, originating in a past significant relationship and being directed toward the patient/client

8 attitudes, feelings and behaviour belonging to a patient/client

9 attitudes, feelings and behaviour belonging to the patient/client, originating in a past significant relationship and being directed toward the therapist

10 I do not know enough about this concept

29. How often are you aware of your subjective feelings and internal reactions when you treat individual clients?

1 Most of the time
2 Often
3 Sometimes
4 Occasionally
5 Seldom
6 I do not treat/see clients

30. How often are you aware of your subjective feelings and internal reactions when you treat couples?

1 Most of the time
2 Often
3 Sometimes
4 Occasionally
5 Seldom
6 I do not treat couples

31. How often does your awareness of your subjective feelings and internal reactions, when treating individuals, factor into decisions about your interventions/treatment strategies?

1 Most of the time
2 Often
3 Sometimes
4 Occasionally
5 Seldom
6 I do not treat/see clients

32. How often does your awareness of your subjective feelings and internal reactions, when treating couples, factor into decisions about your interventions/treatment strategies?

1 Most of the time
2 Often
3 Sometimes
4 Occasionally
5 Seldom
6 I do not treat couples

33. Do you use an awareness of Transference in your clinical practice?

1 Yes 2 No

34. Do you use an awareness of Countertransference in your clinical practice?

1 Yes 2 No

THANK YOU FOR PARTICIPATING IN THIS SURVEY.

Appendix I: Vignette

(Enclosed Vignette)

Heidi B. Gottlieb, Ph.D. Candidate

Vignette – A Couples Case (Crystal and David Hollingsworth)

Crystal and David Hollingsworth have come in for their fourth session today. The following is a brief excerpt from today's counselling session with the therapist. Please answer the corresponding questions to this case vignette, on the accompanying questionnaire. Thank You.

Crystal: I am glad to see you, Dr. Jones. It has been a rough week for us. Not much has changed. I am as unhappy as I was when I first came to see you, and David and I are arguing all of the time. Our home is more like a war zone than the happy haven it is supposed to be... or that it used to be...(Sighs).

David: Frankly, no offence, Doc, but I think this therapy isn't helping and I don't really want to come back anymore. It seems...Well, useless...a waste of our time and money. Nothing seems different, nothing seems to be getting better. I don't really feel like coming back anymore. It's really pointless.

Crystal: (Crying). David, YOU are the one who needs this more than I do...and we BOTH have to be here. You promised. Let's at least try...I love you, David.

David: Fine. I came with you, didn't I? I said I would, and here I am. I love you, too, Crystal.

Crystal: What are we going to do, Dr. Jones? We are so unhappy and we are making our children miserable, too. We were so happy when we were first married...I thought things would be so different...

David: I thought things would be very different, too. (Sighs).

Crystal: I am prepared to do whatever it takes to make our marriage work and so is David. We both just want to be happier...together...and get along better...like before...and like I had hoped and expected...Not like this. (Crying). Everything is a mess now, and everything is going wrong.

David: I thought we were happy, but if Crystal isn't happy, then I want to do whatever it takes to get us back on track. What can I do? (Looks expectantly at Dr. Jones).

Dr. Jones: It sounds like you are both disappointed in how your relationship is, but it also sounds like you both want to work at making your relationship better. Let's talk more about what is going on right now for both of you.

Crystal: I know that David works very hard and he's very tired when he comes home...I know he loves me and would do anything for me. It just seems like even when he is around, he's not...It's hard to explain...Sometimes, at home, he falls asleep when I'm right in the middle of talking to him... and then I feel so hurt...He tells me it's not me, it's him and his work and his schedule, but I feel so badly...Life was so much better when we were dating...We had a great relationship...I thought it would always be like that...

David: Excuse me, Doc, and I'm sorry, Crystal...(Getting up to leave) but I had told you at the beginning of today's session that I would have to leave early...and I have to go now...

Crystal: You see, Dr. Jones? This is what I mean...I was right in the middle of talking, and now he has to leave.

Dr. Jones: Do you need to leave right now, Dr. Hollingsworth?

(Page 1 of 2...)

David: (Snapping). Yes, I told you that at the start and you said it would be okay. I have to deliver a baby tonight and my beeper just went off. You both heard it. What can I do? This is important to me...I love my wife and my marriage means everything to me...She should know that...but I need to go to work...This is my profession...I have to deliver this baby tonight...This is my life. Do you people want me to give it up? Is that what you're saying? Crystal knows I love her, and she knows this is my profession. This is what I do. I need to do this. I have people who are counting on me.

Crystal: I know. (Looking at therapist and crying). I know my husband loves me and is a wonderful man, and I totally love and respect that he is a great doctor...People depend on him...This sounds selfish, but it is almost as if there is no time left over for me or for us...This just seems to be a pattern of our life. I feel like giving up. Is this hopeless? Is there any hope for us? What are we going to do? Can you help us?

Dr. Jones: Dr. Hollingsworth, can you sit for a moment?

David: No, I can't...I'm sorry...I just explained that to you. Crystal can stay on. We came in two separate cars today. I need to leave, though. How many times do I need to say this? You people don't understand.

Dr. Jones: Dr. Hollingsworth, I would have liked you to stay a little longer but I will look forward to seeing you both next Tuesday.

David: Look, Doc...(Snapping). Don't tell me what to do, please. I don't take orders from anyone. I thought we were supposed to discuss things together. We didn't discuss this next appointment. Frankly, all we ever do is talk, talk and more talk, and not get anywhere. We're not accomplishing anything.

Dr. Jones: Okay, Dr. Hollingsworth. Something you may want to think about is that you're angry right now. I can hear how angry and resentful you are now. You may want to think about how you're feeling. We can talk about that next time.

David: Fine, but I don't agree. I also don't find any of the stuff you recommend helpful and I don't find that any of the homework sessions have been useful...In fact, since we've been coming for therapy, Crystal and I have been arguing more and she is even unhappier than before we started counselling. Maybe it's you. Maybe you're not giving us good advice and not helping us.

Dr. Jones: (Uncomfortable). I am trying to help you both. We have a lot of work to do. Let's talk more about this when we all get together next time.

At the end of the session, after the couple has left, Dr. Jones wonders to himself why he did not end today's session the way that he ordinarily would have and could have. Dr. Jones sighs and reviews his written notes from today's session.

Appendix J: Free Gift Flier

*Free Gift**

$25.00 Value

**For returning your completed questionnaire by due date specified. Thank you.*

(Even shipping and handling are free!)

250 FREE PROFESSIONAL CARDS

Your Name / Agency Name / Name of Organization

BARBARA BROOKE
Social Worker/Therapist

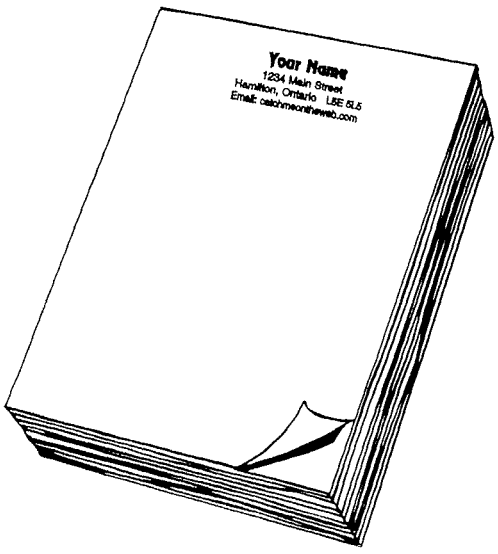
1234 Main Street
Hamilton, Ontario
L5E 5L5

Tel: (905) 573-8000
Fax: (905) 560-8800
Email: catchmeontheweb.com

- *2" x 3.5"*
- *Heavy White Stock*
- *Black Ink*
- *Your choice of typestyle (see inside)*
- *Layout exactly as shown*

Or

250 FREE SHEETS OF PROFESSIONAL / PERSONAL STATIONERY



- *250 Sheets of 5.5" x 8.5" paper*
- *Padded in 50s*
- *Your choice of ink colour*
- *20 lb. White Bond Stock*
- *Layout exactly as shown*

Great Gift for a Friend or an Associate!

ORDER FORM

Please choose one

PLEASE PRINT YOUR NAME, ADDRESS AND PHONE NO. CLEARLY HERE:

(Maximum 40 characters per line)

☐ *250 Professional Cards*

Name _____

Title _____

Agency/Organization Name _____
(if applicable)

Address _____

_____

_____

Fax _____ *Telephone* _____

E-mail _____

☐ *250 Sheets of Professional/Personal Stationery padded in 50s*

Ink Colour: ☐ *Black* ☐ *Green* ☐ *Blue*

Name _____

Address _____

_____

_____

E-mail _____

PLEASE PRINT CLEARLY.

We will try our very best. However, we will not be responsible for any errors.

TYPESTYLES FOR NAME / COMPANY NAME

- ❑ *Times Italic*
- ❑ **Revue Bold**
- ❑ *Vivante Bold*
- ❑ Vagabond

TYPESTYLES FOR TITLE / ADDRESS

- ❑ Times
- ❑ Helvetica
- ❑ Vagabond

❑ *Please ship my order (at no charge) to the following address:*

Name _____

Agency/Organization _____

Address _____

City/Province _____ *Postal Code* _____

Please allow 4-6 weeks for delivery.

Appendix K: Thank-You Note

Thank You

Thank you for responding to my doctoral survey.
I sincerely appreciate your participation in this important research study.
I hope you enjoy your complimentary gift which is absolutely free, and my way of saying "thank you" for your participation.

Sincerely, Heidi
(Heidi Barbara Gottlieb)

Appendix L: Self-Addressed, Postage-Paid Return Envelope

MS. HEIDI B. GOTTLIEB, M.S.W., RSW
PH.D. CANDIDATE (SOCIAL WORK)
PO BOX 94517 RPO THORNHILL EAST
THORNHILL ON L3T 9Z9

Appendix M: Variables Directly from the Questionnaire, and those Variables Calculated from this List

Table M1:

Variables from the Questionnaire (A total of 51 variables)

1	Gender
2	Education
3a	Currently working as a clinical social worker/therapist/counsellor
3b	Previously worked as a clinical social worker/therapist/counsellor
3c	Majority of previous clients/patients treated (in previous clinical experience) were...(i.e. individuals, couples, etc.)
4	Years of practice as a clinical social worker/therapist/counsellor
5a	Current employment setting
5b	Previous employment setting
6a	Majority of current clients/patients are...(i.e. individuals, couples, etc.)
6b	Number of couples currently counselling
7a	Frequency of respondent treating/seeing couples (i.e. once per week, twice per week, etc.)
7b	Treatment format (i.e. conjoint sessions, individual sessions, equal combination of individual and conjoint sessions)
7c	Length of sessions/number of sessions (e.g. 1 - 10 sessions, 11 - 20 sessions, etc.)
8a	Clinical supervision (Yes/No)
8b (Yes)	Number of hours of clinical supervision
8c	Peer supervision/consultation (Yes/No)
8c (Yes)	Number of hours of peer supervision
9a	Type of theoretical model of choice found Most Useful when working with couples
9b	Identification of the three main tenets that characterize the model selected in #9a as Most Useful (if the model chosen was the psychoanalytic one)
10	Respondent's Knowledge (in terms of his/her self-evaluation) of how to approach the case
11a	Type of theoretical model of choice found Most Useful in treating the vignette couple
11b	Identification of overall impression/assessment/three key issues for the vignette couple
11c	Most influential sources of data (identified by respondent)
12a	Did the practitioner have subjective reactions (e.g. thoughts and feelings) to the vignette couple (Yes/No)
12a (Yes)	Subjective reaction – Description/Explanation of the respondent's subjective reactions
12b	Subjective reactions: Would they influence respondent's response/interaction with the vignette couple (Yes/No)
12b (Yes)	Subjective reactions: How would they influence/not influence respondent's response/interaction with the vignette couple
13	Non-verbal communication is/is not as important as verbal communication within the couple system and within the therapeutic triad (between therapist and client couple)

14	Attentiveness to one's own feelings and responses as well as to the client's/client couple's communications
15a	Degree of usefulness of the psychoanalytic model in working with couples (in general)
15a	If practitioner does not use the psychoanalytic model in working with couples: explanation/elaboration of (choice of) one of three options
15b	Degree of usefulness of the psychoanalytic model in working with the vignette couple
15b	If practitioner does not use the psychoanalytic model in working with the vignette couple: explanation/elaboration of (choice of) one of three options
16a	Respondent's subjective reactions to vignette therapist's approach and attitude to these clients/this client couple
16b	Respondent's comments regarding subjective reactions that the vignette therapist may have to these clients/this client couple
17	An accurate description of transference (i.e. defining characteristics)
18	An accurate description of countertransference (i.e. defining characteristics)
19	Transference perception as an obstacle or hindrance to therapy, a helpful component to therapy, or both
20	Countertransference perception as an obstacle or hindrance to therapy, a helpful component to therapy, or both
21	Respondent's consideration of transference in the context of all client systems
22	Respondent's consideration of countertransference in the context of all client systems
23	When/how often practitioners consider transference when working with clients
24	When/how often practitioners consider countertransference when working with clients
25	Respondent's identification of where transference is found
26	Respondent's identification of where countertransference is found
27	Definition of transference (accurate/inaccurate)
28	Definition of countertransference (accurate/inaccurate)
29	Frequency of respondent's awareness of his/her subjective feelings and internal reactions when treating individual clients
30	Frequency of respondent's awareness of his/her subjective feelings and internal reactions when treating couples
31	Frequency with which respondent's subjective feelings and internal reactions, when treating individuals factors into decisions about his/her interventions/treatment strategies
32	Frequency with which respondent's subjective feelings and internal reactions when treating couples, factors into decisions about his/her interventions/treatment strategies

Table M2:

Variables Calculated from the Above List
(A total of 8 variables as indicated in the following table)
(See Appendix B, Coding and Scoring for further details)

1	Index of awareness of transference and countertransference
2	Index of acknowledgment of transference and countertransference
3	Index of understanding of transference and countertransference
4	Index of attitude toward transference and countertransference
5	Overall index of transference and countertransference
6	Index of use of the psychoanalytic model, and of transference and countertransference
7	Theoretical knowledge score
8	Vignette score

Appendix N: Mailing and Data Entry Procedures (Detailed)

The assembling and mailing of the questionnaire packages was an enormous task and required the assistance, enthusiasm and support of several people. This researcher had arranged to have a mailing house, well-experienced in this type of project, to randomly sample 7,100 potential names and addresses from the three mailing lists of potential respondents, and then mail out the stamped, addressed envelopes once this researcher and her assistants had assembled the enclosures. Confidentiality agreements had been made with the printer, printing staff, and the mailing house contracted by this researcher. All names and addresses were kept in strict confidence, used only for purposes of the mailing and then they were destroyed.

After the original designs were made by this researcher (e.g. the questionnaire, cover letter/letter of information, instruction sheet, "free gift" flyer, etc.) and the researcher had received approval for the research study from her Dissertation Committee and the Research Ethics Board of Wilfrid Laurier University, photocopies of all materials were made and a list was developed, outlining the order in which each survey/questionnaire package needed to be assembled.

The researcher trained her two assistants, and then invited interested members of the community to assist in assembling the questionnaire packages and filling the 7,100 envelopes. No names nor mailing addresses were made available at any time. Blank envelopes were filled, and the questionnaires and their matching envelopes were numerically coded for purposes of mailing and coding of responses later on, as well as some initial follow-up with potential respondents.

Most of the members of the community (4-7 in total) were responsible for assembling the mailing packages, in an assembly-line format, with the two persons at the end of the assembly line, double-checking that each package was complete. The researcher and her two research

assistants were the main persons responsible for actually filling the envelopes and confirming that the codes on the outside envelope and the enclosed questionnaire matched.

None of the volunteers who assisted in assembling these questionnaire packages were social workers, nor were they privy to any information related to the study; they had been advised that this researcher was engaged in a doctoral study that involved mailing a survey/questionnaire. The volunteers who offered to help, were supportive of this project.

The assembling of the survey/questionnaire packages, the filling/stuffing of envelopes, and the preparation involved prior to mailing the questionnaires, was an intensive process that took approximately three weeks in total.

The researcher trained her two research assistants in data entry and SPSS, in order to prepare them to assist with the entering of the data once the completed questionnaires were returned. This training process was both intensive and comprehensive, and took approximately two weeks of instruction and practice for the research assistants.

Appendix O: Incentive Raffles and Free Gifts to Respondents, Response Rates, and Respective Due Dates

The incentive draws and free gifts to respondents who completed and mailed back their questionnaire were designed to be an impetus for both early responses and a high response rate. Previous research studies (e.g. Kenyon, 2000) employed an incentive draw and free gifts for respondents to encourage a higher response rate; since this appeared to be a successful incentive, it was also used by this researcher.

Each survey/questionnaire had a cover page with a code stamped on it, corresponding to that respondent (See Appendix F, Cover Page). Respondents were asked to mail back the completed questionnaire with the coded cover sheet still attached in order to be included in an incentive draw/raffle. The two incentive/raffle draws offered three cash prizes of $250, $150, and $100, which corresponded to two separate draws that had an "early" and an "earlier" due date/deadline specified (See Appendix G, Instruction Page). All returned cover sheets were included in the raffles/draws to be conducted, once the due dates for the return of the questionnaires had passed and participants' questionnaires were received. Each questionnaire package was mailed with a cover letter/letter of information and a postage-paid, self-addressed envelope, as well as a "free gift" flier, inviting respondents to participate in this important research study and advising them that an early response would enter them in a cash raffle/draw, and that all respondents would receive a complimentary gift of either professional cards or professional/personalized stationery as a "thank you" for responding to the survey.

All surveys/questionnaires were mailed on March 31st, 2003 with three separate requested response dates: In order to be entered in the Early Bird Draw for a first cash prize of $150 and a second prize of $100, the completed questionnaire was to be returned by April 23rd. In order to be entered in the Bonus Early Bird Draw for a cash prize of $200, the completed questionnaire was to be returned by the earlier date of April 16th. All respondents would receive a free gift of either professional cards or professional/personalized stationery, simply for responding to the

survey and mailing it back by April 28th, 2003, the last due date/deadline specified (See Appendix J, Free Gift Flier). Since several respondents contacted this researcher to request an extension for the due date, the due date was extended to May 16th.

Of interest to note is that of the 1,401 mailed back questionnaires, 333 (23.8%) were returned/mailed back by April 16th, which was the earliest stated deadline in order for respondents to be entered into the Bonus Early Bird Draw, 142 (10.1%) were mailed back by April 23rd, the deadline for the Early Bird Draw, and the remaining 926 (66.1%) were mailed back by April 28th or shortly thereafter (due to the extended two-week deadline). It is interesting to note that 974 respondents (69.5%) had included their order form for their complimentary gift of professional/ personalized cards or personalized stationery. There was a small number of respondents who did *not* include their order form for their free gift of either professional/personalized cards or personalized stationery, and a small number of respondents who indicated that they did not wish to participate in the raffle/draw. Several of these respondents wrote to thank the researcher and comment that, "The incentive gift was a very good idea but not necessary. I am happy to participate in this important study." Additional encouraging comments included by respondents were similar to the following, and reflected their opinions regarding this study: "This is an important research study", "Thank you for doing this relevant research which will be an asset to our field", "This is an important research topic that needs to be studied and will add to clinical practice", and "I am pleased to be a part of this research...Thank you for allowing me to participate."

The incentive draws were conducted on June 11th, 2003. All coded cover sheets had been placed in two separate large boxes and mixed well in preparation for the two respective draws. A volunteer was invited to draw the bonus prize winner in the Bonus Early Bird Draw, and then to draw two winners for the first prize and second prize in the Early Bird Draw, in that specific order. The codes on the respective sheets were then coordinated to the names and addresses on

the master mailing list and the appropriate cheque was sent to each winner, accompanied by a letter which thanked them for their interest and participation in this research study.

Appendix P: Thank-You Letter to Respondents to Accompany Incentive "Thank-You" Gifts

Heidi B. Gottlieb, M.S.W., RSW
Doctoral Candidate
Faculty of Social Work
Wilfrid Laurier University
E-Mail: hbg60@hotmail.com

July, 2003

Dear Social Worker/Therapist/Counsellor;

A while ago, as part of my doctoral programme at Wilfrid Laurier University, Faculty of Social Work, I engaged in a research study to explore attitudes of clinical social workers/therapists/counsellors toward clinical practice, and the use of various theoretical models in clinical practice. You were mailed a questionnaire, a vignette, and an explanatory cover letter/letter of information, inviting you to participate. As well, you were mailed an order form to complete for complimentary professional cards and/or personalized stationery, as an absolutely free gift to "thank you" for participating in this study. This research study was approved by the Wilfrid Laurier University Research Ethics Board.

Enclosed please find the gift that you selected, with my wishes that you enjoy it. Thank you again for your interest and participation in this important study. Your input was valuable and much appreciated, and contributed significantly to the findings. All responses were kept strictly confidential and only recorded and shared in aggregate, anonymous, and coded form. All materials have now been destroyed.

There is very little research that has been done in this area in Canada. Variables in this research study have been drawn from the existing literature in the field, and are designed to add to the body of knowledge in the theoretical realm as well as that of clinical practice and continued research in the field.

The research study was designed to increase understanding of the attitudes of clinical social workers and other helping professionals toward various issues in clinical practice.

The Ontario Association of Social Workers and the Ontario Association for Marriage and Family Therapy will receive copies of the findings of this research. Also, the results of my research may appear in presentations and publications. In the event that quotations may be included in presentations and publications, I will ensure that participants cannot be identified from those quotations. If you would like to receive a summary of the findings of this research study and an outline of the results, please contact me at the phone number listed here, or through my e-mail address. My Web Address will be given to you if/when this becomes available. I expect the results to be available by December 30, 2003. Should you have any questions or if you would like further information about this research study, please contact me at (905) 882-0566.

Thank you again for your cooperation and support by participating in the exploration of this important area of research. I sincerely hope you enjoy your enclosed complimentary "thank-you" gift with my warmest and best wishes for your continued success.

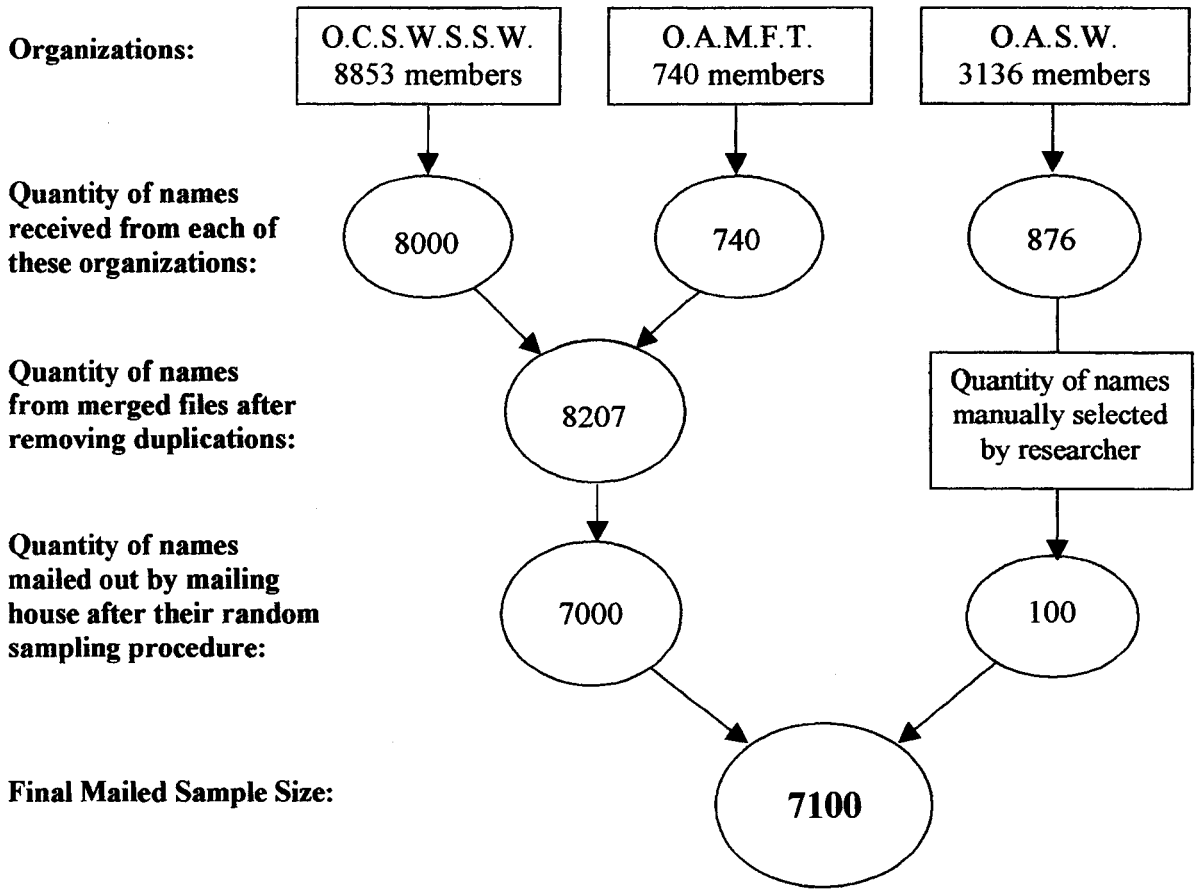
Sincerely,

Heidi B. Gottlieb, M.S.W., RSW
Doctoral Candidate
Faculty of Social Work
Wilfrid Laurier University

E-Mail: hbg60@hotmail.com

Appendix Q: Random Sampling Procedure (Part a)

Figure Q1



Notes on Figure Q1:

A representative sample of social workers and other therapists in Ontario who counsel couples was sought for this research study. The Ontario College of Social Workers and Social Service Workers (O.C.S.W.S.S.W.) had 8853 registered members. Of these, 853 were removed from this list because they were social service workers, leaving the names of 8000 social workers and other registered therapists. This list of O.C.S.W.S.S.W. members' names was merged with the list of names of 740 members of the Ontario Association of Marriage and Family Therapy (O.A.M.F.T.), and then reduced to 7000 names by alternating the removal of first, every 11th name, and then every 12th

name in a random removal process. The Ontario Association of Social Workers (O.A.S.W.) had 3136 members. Of these, 2260 were removed from the list because they were senior and/or retired members that were not currently practising, unemployed members, students, and those practitioners who did not list themselves as specializing in treating individuals or couples, leaving 876 social workers.

A large proportion of the O.A.S.W. membership were also members of the O.C.S.W.S.S.W. and the Ontario Association for Marriage and Family Therapy (O.A.M.F.T). Most of the (876) supplied names from the O.A.S.W. were already accounted for in the other (7000) list, necessitating a manual process of extracting the 200 of those names that were not duplicates. From this list of 200 names, 100 names were then randomly sampled by this researcher by selecting every second name.

Appendix Q: Random Sampling Procedure (Part b)

Letter from the Manager/Owner of Mailing House:

To:
Heidi Gottlieb
PhD Candidate

Report on address file management protocol

The original file contained 8207 records. The file was tagged for the original record order and this was appended to the file. Additional fields were established for the address correction and sorting process. The file was checked for matching names and addresses and three duplicates were removed. Address accuracy and correction routines were applied with 539 uncorrectable records being removed. The remaining records were sorted to CPC Oversized Addressed Admail standards with bag and bundle and delivery mode information being appended to the file. The file at this point had 7665 records remaining all of which contained accurate addresses and valid CPC sort information. As only 7000 addresses were to be used for the mailing 665 records had to be removed. Removal was accomplished by alternately tagging each 11^{th} and then each 12^{th} record from the file in its sorted order. This procedure accomplished the random removal of the required number of records from the address file and established an accurate and valid mailing list containing the required 7000 records.

Subsequently, during the mail assembly process, additional duplicates were uncovered. In total 95 pieces were identified to be removed from the mailing as a result of duplicates and other reasons.

The removed mail pieces were replaced with records from the remaining good records that matched the general geographic destination of the original item. As these substituted pieces would bear the same sort order as the original item this was necessary to maintain the integrity of postal sort. The substituted records were checked to ensure no duplicates were reintroduced.

Every measure has also been taken to ensure that records identified for inclusion or exclusion from the final mailing list has been on a random and unbiased basis. The selection of records used for replacing duplicates was also random but is biased by the requirement for maintaining the integrity of the post office sorting programs.

I believe the final results will meet with your satisfaction within the parameters of the original source data.

Regards

John H Twose
CMS Direct Inc.

Appendix R: Follow-Up Telephone Call Script

Script for Follow-Up Phone Calls to Potential Respondents for Doctoral Questionnaire to be completed and sent back:

Scenario A: If you reach VoiceMail or a Phone Answering machine, please leave the following message, including this important info./these important details and contact info. If you are cut off, please phone back and say that you are continuing the previous message.

Hello. I am phoning for Heidi Gottlieb, Ph.D. Candidate at the Faculty of Social Work, Wilfrid Laurier University. This is an important reminder phone call for you.

If you have already completed and mailed back your questionnaire for the doctoral research study and the order form for your absolutely free "thank you" gift, thank you. That's great.

If you have not yet completed and mailed back the doctoral questionnaire, there is still time to do so. We have extended the due date to May 16th. Please send back your completed questionnaire and order form for your free "thank you" gift before May 16th.

If you need another questionnaire, please phone Heidi at (905) 882 - 0566 in Toronto or e-mail her at hbg60@hotmail.com; hbg as in Heidi Barbara Gottlieb 60 at hotmail.com

Thank you again for your interest and participation in this important research study. It is much appreciated.

Scenario B: If you reach a person, please ask for the respondent by name and say that you are phoning for Heidi Gottlieb. Please try to stick to the information in the script. Do not add nor detract. Do not push, coerce or make anyone feel badly if he/she chooses not to complete and return the questionnaire. If someone opts not to, simply say, "I understand, and thank you. Good-bye."

If anyone asks for additional info. or has questions, my Committee has advised that you simply say that the person can direct his/her questions and/or comments to Heidi at (905) 882 – 0566 in Toronto or e-mail her at hbg60@hotmail.com (Spell this out for the person.) Add that you are only phoning to remind the person to please complete and send back his/her questionnaire; you are not able to respond to these questions nor provide any additional information. (We do not want to bias the respondent nor skew any data by sharing any additional info. re: the research study.)

Hello. I am phoning for Heidi Gottlieb, Ph.D. Candidate at the Faculty of Social Work, Wilfrid Laurier University. This is an important reminder phone call for you.

If you have already completed and mailed back your questionnaire for the doctoral research study and the order form for your absolutely free "thank you" gift, thank you. That's great.

If you have not yet completed and mailed back the doctoral questionnaire, there is still time to do so. We have extended the due date to May 16th. Please send back your completed questionnaire and order form for your free "thank you" gift before May 16th.

If you need another questionnaire, please phone Heidi at (905) 882 - 0566 in Toronto or e-mail her at hbg60@hotmail.com; hbg as in Heidi Barbara Gottlieb 60 at hotmail.com

Thank you again for your interest and participation in this important research study. It is much appreciated.

** Additional Points to Remember:

- Always be warm, friendly and courteous....and sound professional
- Emphasize that the research is for a doctoral research study, that the due date/deadline has been extended to May 16th and the respondent can still receive a completely (absolutely) free gift for responding to the survey/questionnaire. (The free gift is either a set of 250 professional cards or 250 sheets of personalized stationery for him/herself or as a gift for someone else.) The person has a choice of whether or not to respond
- The respondent can feel free to contact the researcher/doctoral candidate who is doing the research study (i.e. Heidi) and give both means of contact (i.e. phone number and e-mail address).

Appendix S: Write-Up of Individual Presentations to Professional Organizations for Proposal Review

The Ontario College of Social Workers and Social Service Workers (O.C.S.W.S.S.W.), the Ontario Association of Social Workers (O.A.S.W.), and the Ontario Association for Marriage and Family Therapy (O.A.M.F.T.) all have their own individual, independent and internal mechanism for the review and potential acceptance of proposals for research studies. Each research study is reviewed and considered on its merit, in terms of its potential contribution to the discipline of Social Work and other counselling-related fields, in the areas of clinical practice, academe, and research.

An initial telephone call was made to these three professional organizations individually, to discuss the proposed research study with each of the respective directors, and to arrange a personal interview in order to discuss the study further. As well, a separate and individualized proposal was prepared for each professional organization, according to the policy and procedures set out by each organization, in addition to providing each of them with a copy of the research proposal that had been prepared for, accepted and approved by the Research Ethics Board of Wilfrid Laurier University.

A personal meeting was arranged with Ms. Glenda McDonald, Registrar of the O.C.S.W.S.S.W. to further discuss the research study and respond to various questions. Two personal meetings were held with Ms. Joan MacKenzie-Davies, Executive Director, O.A.S.W., to discuss the study and the potential participation of O.A.S.W. members. Several telephone meetings were conducted between Ms. Heather McKechnie, President of the O.A.M.F.T. and this researcher, regarding this study and the potential participation of the membership of the O.A.M.F.T.

All professional organizations were assured that the highest ethics would be maintained during the course of this study, all respondents and their responses would be kept private, anonymous

and confidential.

This researcher received the approval and support of the three professional organizations. Mailing lists were given to the researcher with the understanding that they would only be used for purposes of the mailing of the survey/questionnaire package. The O.A.M.F.T. and the O.A.S.W. also provided the e-mail addresses of members for whom this information was available, in order for reminder e-mail messages to be sent to potential respondents. All e-mail messages were sent to potential respondents anonymously, so that each recipient received a "blind copy" (i.e. no name or e-mail address was displayed).

The response from potential respondents and respondents via e-mail and also via telephone calls was positive. Many respondents shared that they believed this to be a very important topic for a research study, they would be very happy to participate in this important study, and that they would like to receive a copy of the findings when they are available, at the conclusion of the study.

Appendix T: Write-Up of Individual Presentation to a Family Service Agency for Proposal Review

During the course of this research study, soon after the questionnaires had been mailed, this researcher was contacted by Ms. Deborah Goodman, Director of the Metropolitan Children's Aid Society (C.A.S.), to advise that various branches of the C.A.S. have their own specific review process for research proposals. This researcher was invited to submit her proposal, and was also advised that she would then be contacted if the agency would be supportive of this study and would like to encourage their employees to participate.

Ms. Goodman stated that the survey/questionnaire packages which had been mailed to employees of the C.A.S. (if they had been randomly sampled from the three mailing lists of the three professional organizations, i.e. the O.C.S.W.S.S.W., the O.A.S.W., and the O.A.M.F.T.) at their business address (i.e. this branch of the C.A.S.) had been "held back", pending an independent review process of this research study by a panel convened for this specific purpose. Having been notified of this policy and protocol concerning this particular branch of the C.A.S., this researcher submitted her research proposal and then gave a follow-up presentation to the panel which included the Director.

The researcher was advised directly after making her presentation that the Director and the panel were very supportive of this important study, the questionnaire packages which had been on "hold" would now be released and distributed to those potential respondents to whom they had been mailed, and the Director also offered to send an e-mail message to staff, advising them of the study, and encouraging them to follow up by participating if they had been selected and had received a questionnaire.

Appendix U: Reminder E-Mail Messages for Respondents (General) – Two drafts to be e-mailed: Introductory e-note and follow-up e-note

Introductory E-Note:

"Heidi B. Gottlieb, M.S.W., RSW, Ph.D. Candidate" <hbg60@hotmail.com> 04/08/03 06:58PM
Re: A Note from your colleague, Heidi B. Gottlieb, M.S.W., RSW, Ph.D. Candidate (Social Work):

As a brief introduction, I am a social worker who has been practising for about 18 years, specializing in individual, couple and family counselling. I have been, and continue to be very committed to our helping profession.

I am currently working on my doctorate, and as part of my doctoral studies at Wilfrid Laurier University, Faculty of Social Work, I am studying attitudes of clinical social workers/therapists/ counsellors toward clinical practice, and the use of various theoretical models in clinical practice. Your attitude is important and will be much appreciated. Variables in this research study have been drawn from the existing literature in the field, and are designed to add to the body of knowledge in the theoretical realm as well as that of clinical practice and continued research in the field.

A questionnaire has been designed to increase understanding of the attitudes of clinical social workers and other helping professionals toward various issues in clinical practice, including general concepts and theoretical considerations as they relate to clinical practice. I am also interested in knowing the attitudes of non-clinical social workers toward the issues covered in the questionnaire and would therefore appreciate participation from these individuals also. Attitude is generally interpreted and understood as an integration of both opinion and feelings toward a particular subject or subject area that culminates in an overall perspective. Your perspective will be much appreciated.

This is an important research study that will contribute significantly to our profession.

A complimentary gift of either professional cards or personalized stationery will be sent to you absolutely free, for completing and sending back the questionnaire in the postage-paid, addressed envelope which will be enclosed. As well, you will be entered in a raffle for cash prizes for early bird responses by the due date specified.

Participation in this research study is voluntary, confidential and anonymous. This is an important research study and your participation will be sincerely appreciated and contribute significantly to the findings. Please be on the lookout for my questionnaire. I hope that you will take the time to complete it and send it back to me.

Sincerely, Heidi B. Gottlieb, M.S.W., RSW, Ph.D. Candidate

Follow-up E-note:

From: Heidi B. Gottlieb, M.S.W., RSW, Ph.D. Candidate (Social Work)
Re: Another Important Message for My Colleagues and An Update

It's not too late! There's still time to mail back your completed questionnaire and receive your complimentary gift!

By popular demand and due to the recent holidays, I have extended the due date/deadline for people who would still like to participate in this important doctoral research study to do so, and also receive the absolutely free gift which is my way of saying "thank you" for your interest and participation in this study.

I appreciate your feedback, and thank you for both your phone calls and e-messages, which I have been trying my best to respond to as promptly as possible.

For those of you who may not have seen the initial e-mail that I sent, which invites potential respondents to participate in my research study and offers further detailed information, I have enclosed it here. (It follows this note.)

Please feel free to contact me via e-mail at hbg60@hotmail.com or by phone at (905)882-0566 (in Toronto) if you require further information, would like to offer any comments regarding this study, or if you are interested in receiving the findings of this study. I will be happy to respond to you.

The new due date/deadline is Friday, May 16th. Please ensure that your completed questionnaires are mailed back by that date, along with your order form for your free gift of professional cards or personalized stationery for yourself or as a gift for someone else.

If you know someone who may be interested in participating in this study (and is a member of either the OASW, OAMFT and/or OCSWSSW), please have him/her contact me directly. If you would be interested in participating in this study and have not received a questionnaire or you cannot locate your copy of a questionnaire, then please contact me and I would be pleased to mail a package to you.

I look forward to, and greatly appreciate your interest and participation in this important research study.

Sincerely, Heidi B. Gottlieb, M.S.W., RSW, Ph.D. Candidate (Social Work)

Appendix V: Reminder E-Mail Message for Respondents (O.A.S.W. and O.A.M.F.T.) (as e-mailed/e-mail version)

"Heidi B. Gottlieb, M.S.W., RSW, Ph.D. Candidate" <hbg60@hotmail.com> 04/08/03 06:58PM
Re: A Note from your colleague, Heidi B. Gottlieb, M.S.W., RSW, Ph.D. Candidate (Social Work):

As a brief introduction, I am a social worker who has been practising for about 18 years, specializing in individual, couple and family counselling. I have been, and continue to be very committed to our helping profession.

I am currently working on my doctorate, and as part of my doctoral studies at Wilfrid Laurier University, Faculty of Social Work, I am studying attitudes of clinical social workers/therapists/ counsellors toward clinical practice, and the use of various theoretical models in clinical practice. Your attitude is important and will be much appreciated. Variables in this research study have been drawn from the existing literature in the field, and are designed to add to the body of knowledge in the theoretical realm as well as that of clinical practice and continued research in the field.

A questionnaire has been designed to increase understanding of the attitudes of clinical social workers and other helping professionals toward various issues in clinical practice, including general concepts and theoretical considerations as they relate to clinical practice. I am also interested in knowing the attitudes of non-clinical social workers toward the issues covered in the questionnaire and would therefore appreciate participation from these individuals also. Attitude is generally interpreted and understood as an integration of both opinion and feelings toward a particular subject or subject area that culminates in an overall perspective. Your perspective will be much appreciated.

This is an important research study that will contribute significantly to our profession.
A complimentary gift of either professional cards or personalized stationery will be sent to you absolutely free, for completing and sending back the questionnaire in the postage-paid, addressed envelope which will be enclosed. As well, you will be entered in a raffle for cash prizes for early bird responses by the due date specified. Participation in this research study is voluntary, confidential and anonymous. This is an important research study and your participation will be sincerely appreciated and contribute significantly to the findings.

Please be on the lookout for my questionnaire. I hope that you will take the time to complete it, and send it back to me.

Sincerely, Heidi B. Gottlieb, M.S.W., RSW, Ph.D. Candidate

Appendix W: Raffle Prize Winner Congratulatory Letter

Heidi B. Gottlieb, M.S.W., RSW
Doctoral Candidate
Faculty of Social Work
Wilfrid Laurier University
E-Mail: hbg60@hotmail.com

July, 2003

Dear Social Worker/Therapist/Counsellor;

A while ago, as part of my doctoral programme at Wilfrid Laurier University, Faculty of Social Work, I engaged in a research study to explore attitudes of clinical social workers/ therapists/counsellors toward clinical practice, and the use of various theoretical models in clinical practice. You were mailed a questionnaire, a vignette, and an explanatory cover letter/letter of information, inviting you to participate. As well, you were mailed an order form to complete, for complimentary professional cards and/or personalized stationery, as an absolutely free gift to "thank you" for participating in this study. As well, you were invited to enter several early bird raffles if your completed questionnaire was mailed back by the due date(s) specified. This research study was approved by the Wilfrid Laurier University Research Ethics Board.

This letter is a follow-up to the telephone call that was made to you earlier, to congratulate you and to advise you that you had won one of the raffles. Enclosed please find the cheque in the amount of $ ___, the prize that you won, with my wishes that you enjoy it. Your name and the information that you were one of the prize winners is being kept confidential and will not be shared with anyone else unless you choose to do so. Thank you again for your interest and participation in this important study. Your input was valuable and much appreciated, and contributed significantly to the findings. All responses were kept strictly confidential and only recorded and shared in aggregate, anonymous and coded form. All materials have now been destroyed.

There is very little research that has been done in this area in Canada. Variables in this research study have been drawn from the existing literature in the field, and are designed to add to the body of knowledge in the theoretical realm as well as that of clinical practice and continued research in the field.

The research study was designed to increase understanding of the attitudes of clinical social workers and other helping professionals toward various issues in clinical practice.

The Ontario Association of Social Workers and the Ontario Association for Marriage and Family Therapy will receive copies of the findings of this research. Also, the results of my research may appear in presentations and publications. In the event that quotations may be included in presentations and publications, I will ensure that participants cannot be identified from those quotations. If you would like to receive a summary of the findings of this research study and an outline of the results, please contact me at the phone number listed below or through my e-mail address. My Web Address will be given to you if/when this becomes available. I expect the results to be available by January, 2004.

Thank you again for your cooperation and support by participating in the exploration of this important area of research. I sincerely hope you enjoy your enclosed gift (a cheque), which was your prize in the raffle. Congratulations again on winning the raffle.

My warmest and best wishes to you for your continued success.

Sincerely,

Heidi B. Gottlieb, M.S.W., RSW
Doctoral Candidate
Faculty of Social Work
Wilfrid Laurier University

E-Mail: hbg60@hotmail.com

Appendix X: Data Analysis Techniques (Detailed)

The initial analysis appropriate for this type of research were descriptive statistics and frequency counts since this research study was an exploratory descriptive one. Some correlational analysis was also done, to explore relationships between variables under consideration and/or possible trends. The SPSS programme was used for the procedure of data analysis for this research study.

Frequencies of all of the variables were run, to identify the proportions of respondents who selected various options as responses on the items, and to examine the values, mean values and standard deviations on specific items, as well as to note the proportions of respondents who attained various scores on the items. These frequencies enabled a calculation of occurrences within each category or the number of times that each level of a variable was selected by respondents to be recorded in percentages, and also allowed for the creation of bar charts of categorical data, pie charts and histograms to further illustrate the presentation of a summary of the data analysis.

Bivariate correlations (using the Pearson r) were run and examined to identify relationships between two variables, and to note any significant relationships where one variable was the predictor variable for another. Any positive or negative trends or tendencies were reported, as well as the strength of that relationship. Bivariate Correlations were also run to compare variables to determine whether or not there was a pattern in their respective levels (trending positively or negatively), and the extent of the patterns using Pearson's r value, and reported where the p value was less than .05; relationships between variables where there was significance were noted, with explanations for the association and implication. Correlation coefficients were used to clarify whether one variable directly corresponded to another (e.g. whether the year of graduation for M.S.W. respondents directly corresponded to an increased sensitivity to, identification and awareness of the concepts of transference and countertransference).

Appendix Y: Overview of Overall Sample

As can be seen in Figure 1, the total number of respondents in the overall sample was 941 (n = 941), which was comprised of 797 (84.7%) social workers and 144 (15.3%) non-social workers (i.e. other helping professionals classified as therapists/counsellors). There were 223 (23.7%) male respondents and 716 (76.3%) female respondents who comprised this sample. Eight respondents indicated on Item/Question #1 that although each of these respondents had circled either "Male" or "Female" as his/her gender, he/she would have preferred to see "Transgendered" listed as another one of the choices. As well, two respondents did not specify his/her gender at all.

The following tables illustrate descriptives for the overall sample of respondents across several variables, including type of practitioner (i.e. social worker or other therapist), gender, education/ degree, present and previous employment experience as a clinical social worker/ therapist/counsellor, years of clinical practice, employment setting, majority (and type) of client/patient systems currently treated, number of couples treated per year, length of sessions, treatment format/modality, supervision, and theoretical orientation.

Table Y1

Overall Sample (n = 941)

Respondents	n	%
Social Workers	797	84.7
Other Therapists	144	15.3

*missing data = 0

Table Y2

Gender (Item #1) (n = 939)

Male	Female
223 (23.7%)	716 (76.3%)

*missing data = 2

Table Y3

Education: (Item #2) (n = 941)

Degree	n	%
B.S.W.	167	17.7
B.S.W. and M.S.W.	219	23.3
M.S.W.	411	43.7
M.A. in Pastoral Counselling/Divinity/Theology	55	5.8
M.A. in Psychology	18	1.9
Other Degrees	71	7.5

*missing data = 0

Included in the above table were practitioners who had the following degrees:

38 Social Work related certificate
8 Psychology related certificate
18 Psychoanalytic certificate/training
34 OAMFT/AAMFT clinical members/supervisors
14 Ph.D. in Social Work
7 Ph.D. in Psychology
2 Ph.D. in Pastoral Counselling
11 Ph.D. in other fields

All respondents (n = 941) are "presently working as a clinical social worker/therapist/counsellor" which was criteria for inclusion in this research study, and the majority of respondents have previously worked in this capacity; 92 (10.5%) did not. Sixty-eight respondents did not respond to/omitted this question (Item #3b). The majority of respondents indicated "individuals" to describe the majority of client/patient systems treated by them in their previous experience as a clinical social worker/therapist/counsellor.

Table Y4

Previous client/patient systems treated (Item #3c) (n = 783)

Individuals	Couples	Other
532 (67.9%)	131 (16.7%)	120 (15.3%)

*missing data = 158

One hundred and fifty-eight were classified as missing data since they had either missed or omitted the question, or had circled more than one choice that did not include "individuals" or "couples".

For years of practice, (Item #4), the mean was 14.6 years with a Standard Deviation of 9.2 years.

Table Y5

Employment Setting (Item #5a) (n = 847)

Employment setting	n	%
Private practice	192	22.7
Hospital – mental health	178	21.0
Hospital – medical	117	13.8
Social agency setting	102	12.0
Family service agency	83	9.8
School setting	34	4.0
Academic/Teaching	24	2.8
Correctional setting	13	1.5
Organizational setting	3	0.4
Other	101	11.9

*missing data = 94

As illustrated in Table Y5, the largest number of respondents work in private practice, the second largest number of respondents work in hospital – mental health settings, the third largest number work in hospital – medical settings, and the next largest number of respondents work in social agency settings.

Table Y6

Current Client/Patient Systems (Item #6a) (n = 940)

Individuals	Couples	Other
684 (72.7%)	156 (16.6%)	100 (6.6%)

*missing data = 1

In terms of clinical practice, the majority of respondents chose "individuals" to describe the majority of clients/patient systems they currently treat (Item #6a), and a small number of respondents chose "couples". (Table Y6)

Theoretical Orientation – as related to couples in general (Item #9a):

When asked about the type of theoretical model found to be most useful in working with couples (Item #9a), the largest number of respondents chose "Systems" as their first choice. The

next model of choice was "Cognitive Behavioural"; the third most popular response was "Eclectic".

The majority of respondents did not choose the Psychoanalytic model as their *first choice* in treating couples, in general. (Table Y7). An interesting finding was that 109 (17.6%) respondents *did consider* the Psychoanalytic model as a useful model when working with couples, in general, as indicated when they selected this model as *one of their top three choices.*

Table Y7

Theoretical Model (Item #9a) (n = 621)

Theoretical Model	**n**	**%**
Systems	108	17.4
Cognitive Behavioural	105	16.9
Eclectic	98	15.8
Communication	73	11.8
Emotionally Focused	69	11.1
Psychoanalytic	38	6.1
Other	130	20.8

*missing data = 320

Theoretical Orientation – as related to the couple in the vignette (Item #11a):

In Item #11a (n = 908), where respondents were asked to choose the Most Useful model, in terms of a more specific case scenario (i.e. Here, they were asked to select the most useful model for treating the couple in the vignette), only a very small number of respondents (54 = 5.9%) chose the Psychoanalytic model as their *first choice.* Of interest to note is that a small number of respondents (142 = 15.6%) demonstrated that the Psychoanalytic model was *a consideration* for them in treating the vignette couple, as indicated by their selection of this model as *one of their top three choices.*

Appendix Z: Overview of Couples Counsellors Sample

The following descriptive statistics and corresponding commentary are based upon frequencies for this sample of couples counsellors composed of 654 respondents.

2. Primary Sample (Couples Counsellors):

As seen in Figure 1 (p. 118) and Table Z1, the total number of respondents in our primary sample of practitioners who engage in couples counselling is 654.

Gender (Item #1) and the Key Indices:

As illustrated in Table Z2, female respondents represent the majority of respondents who comprise this subsample. There are no gender differences in terms of scoring on the key indices, as measured by a t-test.

Table Z1

Primary Sample (n = 654)

Respondents	n	%
Social Workers	532	81.3
Other Therapists	122	18.7

*missing data = 0

Table Z2

Gender (n = 652) (Item #1)

Male	Female
178 (27.3%)	474 (72.7%)

*missing data = 2

Education (Item #2) and the Key Indices:

In terms of an overall breakdown of the primary sample of 654 couples counsellors, Table Z4 outlines the proportions of social workers and other therapists, in terms of their professional degrees.

Table Z3

Education (n = 654) (Item #2)

Degree	n	%
B.S.W.	94	14.4
B.S.W. & M.S.W.	153	23.4
M.S.W.	285	43.6
M.A. in Pastoral Counselling/Divinity/Theology	41	7.3
M.A. in Psychology	9	2.0
M.A. in Marriage, Family and Child Counselling	9	1.5
M.A. in Counselling-related discipline	43	0.9
Other Degrees	20	6.9

*missing data = 0

Included in the above table were practitioners who had the following degrees:
21 Social Work related certificate
8 Psychology related certificate
11 Psychoanalytic certificate/training
30 OAMFT/AAMFT clinical members/supervisors
12 Ph.D. in Social Work
6 Ph.D. in Psychology
2 Ph.D. in Pastoral Counselling
9 Ph.D. in other fields

The majority of respondents in this sample are social workers who also have their M.S.W. degree. (Further details concerning this subsample of social workers who do couples counselling may be found on pp. 120-138).

Present and Previous Professional/Clinical Experience (Item #3b):

All respondents are "presently working as a clinical social worker/therapist/counsellor" which was criteria for inclusion in this research study, and the majority had previously worked in this capacity, in another employment setting. (See Table Z4).

Table Z4

Previously Employed as a Clinical Social Worker/Therapist/Counsellor (Item #3b) (n = 601)

Previously employed	Not previously employed
546 (90.8%)	55 (8.4%)

*missing data = 53

While previous professional/clinical experience (Item #3b) did not prove to be a significant factor for most of the other variables or key indices (i.e. awareness, acknowledgment, understanding, attitude and the overall index), it did prove to be a significant factor for practical application/use. Out of 601 respondents, practitioners with previous employment experience as clinical social workers/ therapists/counsellors scored higher (mean score of 1.53, S.D. = 1.26) on use/application than those who did not have previous employment experience as a clinical social worker/therapist/counsellor (55 = 9.2%) who scored a mean of 1.18 (S.D. = .98). The mean difference was .34. A t-test was performed, and found that previous professional/clinical experience was statistically significant as it relates to score on use/practical application. $t(73.4) = 2.41$, $p = .018$. Previous professional/clinical experience that practitioners have, does influence how they scored on application/use. This would suggest that practitioners with previous professional/clinical experience would be more likely to have a better/higher score on use/application, and be more likely to use psychoanalytic approaches, and the concepts of transference and countertransference.

Majority of Client Systems Treated in Previous Professional/Employment Experience (Item #3c):

The majority of client/patient systems treated by most respondents in the past, was "individuals"(as shown in Table Z5). The second largest group of respondents had indicated "couples" as the majority of client/patient systems whom they had treated in their previous clinical experience.

Table Z5

Previous Client/Patient Systems (Item #3c) (n = 548)

Individuals	Couples	Families	Groups	Other
337 (51.6%)	117 (17.9%)	82 (12.6%)	6 (0.9%)	6 (0.9%)

*missing data = 106

An ANOVA was performed to test for the differences in mean scores on the key indices that exist between the couples counsellors who work with different types of client systems. (Table Z5). No significant differences were found.

Years of Practice (Item #4):

For years of practice, the mean was 15.31 years (S.D. = 9.01 years).

The years of professional/clinical practice that practitioners have, did not prove to be a significant factor on any of the key indices other than attitude. Years of experience were positively correlated to attitude. ($r = .086$, $p = .029$).

Current Employment Setting (Item #5a):

The largest number of respondents currently work in private practice, as illustrated in Table Z6, with the second largest group represented working within a hospital setting – mental health unit.

Table Z6

Current Employment Setting (Item #5a) (n = 577)

Employment setting	**n**	**%**
Private Practice	173	30.0
Hospital – Mental Health	105	18.2
Family Service Agency	71	12.3
Social Agency Setting	60	10.4
Hospital – Medical	55	9.5
Academic/Teaching	18	3.1
School Setting	16	2.8
Organizational Setting	3	0.5
Correctional Setting	2	0.3
Other	74	12.8

*missing data = 77

ANOVA tests were performed to test for differences in mean index scores by couples counsellors' current employment settings, and only the differences on the overall index where $F(9, 567) = 2.28$, $p = .016$ (Table Z7), and use, where $F(9, 567) = 2.24$, $p = .018$ (Table Z8) were

significant. Fisher's LSD multiple comparison tests were performed on the means to further investigate the mean differences.

As illustrated in Table Z8, respondents who are currently employed in family service agency settings scored higher on the overall index of transference and countertransference than respondents employed in other settings. Those respondents currently employed in academic/teaching settings scored highest on the overall index than respondents employed in other settings. Those respondents currently employed in hospital-mental health settings scored second highest on this index, when compared to respondents currently employed in other settings.

Table Z7

LSD Test Comparing Mean Differences of Current Employment Settings Based on Scoring on **the Overall Index of Transference and Countertransference**

Higher Scoring	mean	Lower Scoring	mean	Mean Difference	p
Family Service Agency	6.08	Social Agency Setting	5.62	.46	.042
Hospital-Mental Health	6.27	Private Practice	5.93	.34	.033
Hospital-Mental Health	6.27	Social Agency Setting	5.62	.65	.002
Hospital-Mental Health	6.27	Hospital-Medical	5.70	.57	.008
Academic/Teaching	6.48	Social Agency Setting	5.62	.86	.013
Academic/Teaching	6.48	Hospital-Medical	5.70	.78	.026

As illustrated in Table Z8, respondents who work in private practice scored higher on the index of use/practical application than respondents who work in social agency and hospital-medical settings. Respondents in academic/teaching settings scored highest on this index than those respondents who work in all other types of settings. Those respondents in private practice scored second highest on this index when compared with respondents who work in other types of settings.

Table Z8

LSD Test Comparing Mean Differences of Current Employment Settings Based on Scoring on **the Index of Use of the Psychoanalytic Model, and of Transference and Countertransference**

Higher Scoring	mean	Lower Scoring	mean	Mean Difference	p
Private Practice	1.69	Social Agency setting	1.15	.54	.003
Private Practice	1.69	Hospital-Medical	1.31	.39	.039
Hospital–Mental Health	1.59	Social Agency setting	1.15	.44	.026
Academic/Teaching	1.90	Social Agency setting	1.15	.75	.022

Previous Employment Setting (Item #5b):

ANOVA tests were performed to investigate differences between couples' counsellors' previous employment settings and their mean scores on the key indices. Significant differences were found for the variables of awareness where $F(9, 479) = 2.39$, $p = .012$ (Table Z9), understanding where $F(9, 479) = 3.43$, $p = .001$ (Table Z10), and the overall index where $F(9, 479) = 3.34$, $p = .001$ (Table Z11).

As illustrated in Table Z11, in general, the respondents who had previously worked in private practice scored highest on the index of awareness of transference and countertransference than respondents who had previously worked in other settings. Respondents who had previously worked in a correctional setting scored lowest on this index than respondents whose previous employment experience was in another type of setting.

Table Z9

LSD Test Comparing Mean Differences of Previous Employment Settings Based on Scoring on **the Index of Awareness of Transference and Countertransference**

Higher Scoring	mean	Lower Scoring	mean	Mean Difference	p
Private Practice	6.47	Social Agency setting	5.57	.90	.008
Private Practice	6.47	Family Service agency	5.53	.94	.008
Private Practice	6.47	Hospital-Medical	5.32	1.16	.002
Private Practice	6.47	Correctional setting	4.59	1.89	.001
Private Practice	6.47	Academic/Teaching	5.28	1.19	.028
Social Agency setting	5.57	Correctional setting	4.59	.98	.023
Family Service agency	5.53	Correctional setting	4.59	.94	.034
Hospital-Mental health	5.96	Hospital-Medical	5.32	.64	.030
Hospital-Mental health	5.96	Correctional setting	4.59	1.37	.002
School setting	6.05	Correctional setting	4.59	1.46	.007

As illustrated in Table Z10, in general, the respondents who had previously worked in private practice scored highest on the index of understanding of transference and countertransference than respondents who had previously worked in other settings. Those respondents who had previously worked in hospital-mental health settings scored second highest on this index than respondents who had previously worked in other settings.

Table Z10

LSD Test Comparing Mean Differences of Previous Employment Settings Based on Scoring on **the Index of Understanding of Transference and Countertransference**

Higher Scoring	mean	Lower Scoring	mean	Mean Difference	p
Private Practice	5.99	Family Service agency	4.64	1.35	.001
Private Practice	5.99	Hospital-Medical	4.96	1.03	.012
Private Practice	5.99	School setting	4.35	1.64	.001
Social Agency setting	5.29	Family Service agency	4.64	.65	.009
Social Agency setting	5.29	School setting	4.35	.95	.024
Hospital-Mental health	5.64	Family Service agency	4.64	1.00	.001
Hospital-Mental health	5.64	School setting	4.35	1.29	.004

As illustrated in Table Z11, in general, those respondents who had previously worked in private practice scored higher on the overall index of transference and countertransference than respondents who had worked in other settings. Respondents whose previous employment setting was hospital-mental health also scored higher on this index than respondents who had previously worked in a different type of setting.

Table Z11

LSD Test Comparing Mean Differences of Previous Employment Settings Based on Scoring on **the Overall Index of Transference and Countertransference**

Higher Scoring	mean	Lower Scoring	mean	Mean Difference	p
Private Practice	6.64	Social Agency setting	5.87	.77	.003
Private Practice	6.64	Family Service agency	5.73	.91	.001
Private Practice	6.64	Hospital-Medical	5.66	.98	.001
Private Practice	6.64	Correctional setting	5.48	1.15	.002
Hospital-Mental Health	6.34	Social Agency setting	5.87	.47	.009
Hospital-Mental Health	6.34	Family Service agency	5.73	.62	.002
Hospital-Mental Health	6.34	Hospital-Medical	5.66	.69	.002
Hospital-Mental Health	6.34	Correctional setting	5.48	.86	.010

Majority of Client Systems Currently Being Treated (Item #6a):

In terms of clinical practice, the majority of respondents chose "individuals" to describe the majority of clients/patient systems they currently treat (Table Z12), and the second largest group of respondents chose "couples".

Table Z12

Current Client/Patient Systems (Item #6a) (n = 653)

Individuals	Couples	Families	Groups	Other
410 (62.8%)	146 (22.4%)	82 (12.6%)	11 (1.7%)	4 (0.6%)

*missing data = 1

An ANOVA test was performed to compare the mean scores on the key indices, of couples' counsellors who work with different client systems (Table Z12). No significant differences were found.

Number of Couples Treated (Item #6b):

The mean number of couples treated per year by respondents in this sample is 24.9 couples (S.D. = 41.7). A slight negative correlation was found between the number of couples treated and mean scores on acknowledgment ($r = -.102$, $p = .009$), attitude ($r = -.089$, $p = .023$) and the overall index ($r = -.088$, $p = .025$). This suggests that the greater the number of couples treated by respondents, the less likely these respondents would be to acknowledge transference and countertransference, and the less likely they would be to have a positive attitude toward these concepts; as well, these respondents would not perform well on the overall index of transference and countertransference. On further investigation, it was discovered that this was only the case for respondents who saw very large numbers of couples. (When respondents who saw 100 or more couples were removed from the sample, there were no significant correlations.)

Frequency with which Couples are being Counselled (Item #7a):

In terms of the frequency with which clinicians counsel couples, the greatest number of respondents treat couples once per week, with the next being once every two weeks. (Table Z13).

A bi-variate correlation was run to determine whether there was an association between the frequency with which couples counsellors see/treat couples and their scores on the key indices. There was no significant correlation.

Table Z13

Frequency with which Clinicians Counsel Couples (Item #7a) (n = 642)

Frequency	n	%
Once per week	185	28.8
Once every 2 weeks	165	25.7
Two or more times a week	105	16.4
Once every 5 - 16 weeks	94	14.6
Once every 4 weeks	60	9.3
Once every 3 weeks	30	4.7
Never	3	0.5

*missing data = 12

Table Z14

Treatment Format (Item #7b) (n = 639)

Format	n	%
Conjoint sessions	398	62.3
Equal combinations of individual and conjoint sessions	208	32.6
Individual sessions	33	5.2

*missing data = 15

Type of Treatment Format (Item #7b):

The majority of respondents treat couples in conjoint sessions (as a couple together), with the second largest number of respondents treating the couple system through an equal combination of individual and conjoint counselling sessions. The smallest number of respondents treat couples by working with partners/mates individually. (Table Z14).

Type of treatment format proved to be a significant factor for awareness, the overall index, and application/use. The (greater the) use of conjoint sessions as a treatment format was positively correlated with: the score on awareness. ($r = .118$, $p = .003$), score on the overall index. ($r = .10$, $p = .012$), and score on use ($r = .115$, $p = .004$).

Length of Treatment (in Number of Sessions) (Item #7c):

Most respondents treat clients in 1 – 10 sessions, which this researcher has classified as Brief Therapy, the second largest group of respondents treat clients in 11 – 20 sessions, and only a small number of respondents (4.6%) treat clients in 21 or more sessions, which this researcher has classified as Long-Term or more intensive therapy. Of interest to note is that 5.0% respondents selected "Not Sure" as their response, suggesting that they did not know how many sessions they would use, in general, to treat couples. (Table Z15).

Length of treatment (in number of sessions) was positively correlated to the score of acknowledgment ($r = .17$, $p = .001$), the score of attitude ($r = .11$, $p = .009$), the score on overall index ($r = .15$, $p = .001$), and the score of use ($r = .32$, $p = .001$). This suggests that the longer the treatment that a respondent employs to treat couples, the more likely he/she would be to acknowledge transference and countertransference, and have a positive attitude toward these concepts and the more likely he/she would be to use them and the psychoanalytic model in his/her practice. This respondent would also be more likely to perform well on the overall index of transference and countertransference.

Table Z15

Length of Treatment – in Number of Sessions (Item #7c) (n = 525)

Number of Sessions	n	%
1 – 10 sessions	380	72.4
11 – 20 sessions	95	18.1
21 or more session	24	4.6
Not sure	26	5.0

*missing data = 7

Clinical Supervision (Items #8a and #8b):

Regarding clinical supervision, less than half of respondents have a clinical supervisor, as indicated with a "Yes" response; however, the majority of respondents do not have a clinical supervisor (Table Z16). Of the respondents who have a clinical supervisor, the largest group

receives 2 – 3 hours of supervision per month, with the next largest group receiving 1 hour per month. A small number of respondents indicated that they receive no (hours of) supervision per month, and an even smaller number indicated that they receive the greatest amount of supervision (i.e. 6 or more hours per month). (Table Z17).

A t-test was performed and demonstrated that there were no significant differences between couples counsellors who received clinical supervision and those who did not (Table Z16), in terms of scoring on the key indices.

There was no significant correlation found between the number of hours of clinical supervision (Table Z17) and how practitioners scored on the key indices of knowledge and use.

Table Z16

Clinical Supervision (Item #8a) (n = 650)

Supervision	n	%
Yes	291	44.8
No	359	55.2

*missing data = 4

Table Z17

Hours of Clinical Supervision per Month (Item #8b) (n = 286)

Hours of supervision	n	%
2 – 3 hours	101	35.3
1 hour	88	30.8
4 – 5 hours	50	17.5
0 hours	18	6.3
6 or more hours	16	5.6
Other	13	4.5

*missing data = 368

Table Z18

Peer Supervision (Item #8c) (n =650)

Supervision	n	%
Yes	474	72.9
No	176	27.1

*missing data = 4

Peer Supervision (Item #8c):

The majority of respondents receive peer supervision/consultation. (Table Z18). Of those respondents who receive peer supervision, the mean was 3.42 hours with a Standard Deviation of 2.67 hours.

A t-test was performed and demonstrated that there was a significant difference between those couples counsellors who received peer supervision (and those who did not) (Table Z18), on the overall index and on use. Practitioners who received peer supervision scored higher on the overall index than those who did not receive peer supervision. The mean difference was .26, $t(648) = 2.23$, $p = .026$ Practitioners who received peer supervision scored higher on use than those who did not receive peer supervision. The mean difference was .22, $t(364.7) = 2.14$, $p = .033$ A significant positive correlation was only found between the number of hours of peer supervision received and the scoring on acknowledgment ($r = .114$, $p = .017$). This suggests that practitioners who received more hours of peer supervision were more likely to acknowledge transference and countertransference.

Theoretical Orientation – as related to couples in general (Item #9a):

It is relevant to note that when asked about the type of theoretical model found to be "Most Useful" in working with couples, the largest number of respondents chose "Systems" as their first choice. The second model of choice was "Cognitive Behavioural", and the third most popular response was "Eclectic". (Table Z19 outlines the choices of theoretical orientations in further detail.)

Table Z19

Theoretical Orientation (Item #9a) (n = 621)

Theoretical Model	n	%
Systems	108	17.4
Cognitive Behavioural	105	16.9
Eclectic	98	15.8
Communication	73	11.8
Emotionally Focused	69	11.1
Psychoanalytic	38	6.1
Insight-Oriented	26	4.2
Cognitive	25	4.0
Behaviour	14	2.3
Social Learning	4	0.6
Role	3	0.5
Ecological	3	0.5
Not Sure	9	1.4
Other	46	7.4

*missing data = 33

It is clearly demonstrated that the majority of respondents did not choose the psychoanalytic model, in general, when treating couples. Of interest to note is that while a very small number of respondents selected the psychoanalytic model as their *first* choice in treating couples, this model *was a consideration* as a useful model for a greater number of respondents (109 = 17.6%) which was indicated when they selected this model as *one of their top three choices* in treating couples (in #9a).

Test for Theoretical Orientation Significance:

An ANOVA test was performed on couples counsellors with different theoretical orientations, to test for significant mean differences in scoring on the key indices. The following indices proved to be significant: awareness where $F(13, 607) = 1.75$, $p = .048$ (Table Z20) , acknowledgment where $F(13, 607) = 2.72$, $p = .001$ (Table Z21), attitude where $F(13, 607) = 5.15$, $p = .001$ (Table Z22), overall index where $F(13, 607) = 4.66$, $p = .001$ (Table Z23), and use where $F(13, 607) = 61.09$, $p = .001$ (Table Z24).

On awareness, respondents who were psychoanalytically oriented scored higher than all of the other couples counsellors with different theoretical orientations. (Table Z20). Couples counsellors who chose the Emotionally Focused orientation scored significantly higher than those who chose the Cognitive Behavioural orientation; perhaps this could best be explained by the Emotionally Focused model incorporating many aspects of the psychoanalytic model and being classified as a model which falls under the category of "psychoanalytic". In comparing psychoanalytically oriented couples counsellors with emotionally-focused couples counsellors, the mean difference was 0.43, $p = 0.21$ (non-significant). The psychoanalytically oriented couples counsellors scored higher on awareness than the emotionally-focused couples counsellors, but this difference was not statistically significant.

Table Z20

LSD Test Comparing Mean Differences of Theoretical Orientation Based on Scoring on **the Index of Awareness of Transference and Countertransference**

Higher Scoring	mean	Lower Scoring	mean	Mean Difference	p
Psychoanalytic	6.42	Cognitive Behavioural	5.19	1.23	.001
Psychoanalytic	6.42	Eclectic	5.54	.88	.006
Psychoanalytic	6.42	Systems	5.56	.86	.007
Psychoanalytic	6.42	Communication	5.71	.71	.034
Emotionally Focused	5.99	Cognitive Behavioural	5.19	.80	.002

Theoretical orientation also proved to be a significant influential factor on acknowledgment of transference and countertransference.

Of all the groups of respondents, those who had chosen the psychoanalytic model as their orientation attained the highest mean score on acknowledgment of transference and countertransference. (Table Z21). A second tier of high mean scores could be found with the insight-oriented, systems, and communication groups of respondents. This may be explained best by the premise of psychoanalytic theory being predicated on the affective or emotional components, such as sensitivity, awareness, and attunement. The insight-oriented, systems, and

communication models all incorporate these aspects of the psychoanalytic model, and may therefore explain why respondents with this theoretical orientation scored higher on acknowledgment or recognition of the transferential and countertransferential concepts.

Table Z21

LSD Test Comparing Mean Differences of Theoretical Orientation Based on Scoring on **the Index of Acknowledgment of Transference and Countertransference**

Higher Scoring	mean	Lower Scoring	mean	Mean Difference	p
Psychoanalytic	7.81	Cognitive Behavioural	5.94	1.87	.001
Psychoanalytic	7.81	Eclectic	5.85	1.96	.001
Psychoanalytic	7.81	Systems	6.17	1.63	.001
Psychoanalytic	7.81	Communication	6.24	1.56	.002
Psychoanalytic	7.81	Emotionally Focused	6.09	1.72	.001

Theoretical orientation also proved to be a significant influential factor on attitude toward transference and countertransference. Of all the groups of respondents, those who had chosen the psychoanalytic model as their orientation attained the highest mean score on attitude toward transference and countertransference. (Table Z22).

Table Z22

LSD Test Comparing Mean Differences of Theoretical Orientation Based on Scoring on **the Index of Attitude toward Transference and Countertransference**

Higher Scoring	mean	Lower Scoring	mean	Mean Difference	p
Psychoanalytic	8.52	Cognitive Behavioural	6.63	1.89	.001
Psychoanalytic	8.52	Eclectic	6.94	1.58	.001
Psychoanalytic	8.52	Systems	6.94	1.58	.001
Psychoanalytic	8.52	Communication	6.88	1.64	.001
Psychoanalytic	8.52	Emotionally Focused	7.16	1.36	.001

Theoretical orientation proved to be a significant influential factor on the overall index of knowledge of transference and countertransference.

The psychoanalytically oriented respondents/practitioners (i.e. those respondents who had chosen this model when describing their orientation through their selection of their first model of

choice/preference) scored the highest on the overall index of knowledge of transference and countertransference. (Table Z23). The Emotionally Focused group scored the second highest on the index; this could be because the Emotionally Focused model is psychodynamic/ psychoanalytic in nature and has aspects which also belong to the psychoanalytic model (e.g. affective components, insight, etc.). Systems and communication groups were the next highest scoring respondents on the index of knowledge; this may be explained best because these two models focus on the interactional/ interpersonal components which are integral to couples counselling.

Table Z23

LSD Test Comparing Mean Differences of Theoretical Orientation Based on Scoring on **the Overall Index of Transference and Countertransference**

Higher Scoring	**Mean**	**Lower Scoring**	**mean**	**Mean Difference**	**p**
Psychoanalytic	7.08	Cognitive Behavioural	5.79	1.29	.001
Psychoanalytic	7.08	Eclectic	5.79	1.29	.001
Psychoanalytic	7.08	Systems	6.01	1.06	.001
Psychoanalytic	7.08	Communication	6.06	1.02	.001
Psychoanalytic	7.08	Emotionally Focused	6.16	.91	.001

Theoretical orientation was also statistically determined to be a significant influential factor for application/use, with the psychoanalytically oriented respondents/practitioners scoring the highest.(Table Z24). While psychoanalytically oriented respondents scored much higher than respondents with other theoretical orientations, one needs to consider that additional points were given to respondents who chose the psychoanalytical model.

Table Z24

LSD Test Comparing Mean Differences of Theoretical Orientation Based on Scoring on **the Index of Use of the Psychoanalytic Model, and of Transference and Countertransference**

Higher Scoring	mean	Lower Scoring	mean	Mean Difference	p
Psychoanalytic	5.18	Cognitive Behavioural	1.07	4.11	.001
Psychoanalytic	5.18	Eclectic	1.34	3.84	.001
Psychoanalytic	5.18	Systems	1.31	3.88	.001
Psychoanalytic	5.18	Communication	1.24	3.94	.001
Psychoanalytic	5.18	Emotionally Focused	1.61	3.57	.001
Emotionally Focused	1.61	Cognitive Behavioural	1.07	.54	.001
Emotionally Focused	1.61	Systems	1.34	.30	.019
Emotionally Focused	1.61	Eclectic	1.31	.27	.039
Emotionally Focused	1.61	Communication	1.24	.37	.009

Again, on application/use, respondents who had a Psychoanalytic orientation attained the highest mean score, with respondents who had an Emotionally Focused orientation attaining the next highest score on use/application. Since the Emotionally Focused model can be classified as a psychodynamic/psychoanalytic model, this could explain why respondents with this theoretical orientation scored second highest on use/application.

In concluding this section on theoretical orientation, we can state that this variable (i.e. theoretical orientation) was influential on the scoring of awareness, acknowledgment, attitude, the overall index and application/use for couples counsellors, and this was statistically significant. While there were differences in the mean scores on understanding, nevertheless, the variable of understanding, proved to be non-significant as it relates to theoretical orientation.

Theoretical Orientation - as related to couples in general (Item #9a):

Table Z25

Scores on the Key Indices by Theoretical Orientation: Couples Counsellors (n = 621) (Six largest groups)

Theoretical Orientation	n	Awareness Score	Acknow-ledgment Score	Under-standing Score	Attitude Score	Overall Index Score	Use Score
Systems	108	5.56 S.D.= 1.66	6.17 S.D. = 2.34	5.38 S.D. = 1.99	6.94 S.D. = 1.83	6.01 S.D. = 1.33	1.31 S.D.=.85
Cognitive Behavioural	105	5.19 S.D. =1.57	5.94 S.D. = 2.36	5.40 S.D. = 1.91	6.63 S.D. = 1.73	5.79 S.D. = 1.13	1.07 S.D.=.73
Eclectic	98	5.54 S.D. = 1.65	5.85 S.D. = 2.76	4.84 S.D. = 1.91	6.94 S.D. = 2.15	5.79 S.D. = 1.42	1.34 S.D.=.84
Communi-cation	73	5.71 S.D. = 1.86	6.24 S.D. = 2.62	5.40 S.D. = 1.72	6.88 S.D. = 1.49	6.06 S.D. = 1.19	1.24 S.D.=.63
Emotionally Focused	69	5.99 S.D. = 1.39	6.09 S.D. = 2.71	5.42 S.D. = 1.88	7.16 S.D. = 1.61	6.16 S.D. = 1.16	1.61 S.D.=.98
Psycho-analytic	38	6.42 S.D. = 1.75	7.81 S.D. = 2.38	5.56 S.D. = 1.32	8.52 S.D. = 1.27	7.08 S.D. = 1.09	5.18 S.D.=1.36

Of all respondents in this sample, those who were psychoanalytically oriented attained better scores on the key indices. (Table Z25)

Identification of 3 Main Tenets or Key Concepts of the Psychoanalytic Model (Item #9b):

Of the 38 respondents who chose the psychoanalytic model as their Most Useful theoretical model (in #9a), there was (in #9b) a total of 92 correctly identified main tenets or key concepts that characterize this (psychoanalytic) model, with 35 of the respondents identifying at least one correct tenet.

Theoretical Orientation – as related to the couple in the vignette (Item #11a):

On Item #11a (n = 630), where respondents were asked to choose the Most Useful model, in terms of a more specific case scenario (i.e. they were asked to select the most useful model for treating the couple in the vignette), a very small number of respondents (43 = 6.8%) selected the psychoanalytic model as their *first* choice in treating the couple in the vignette. This model was *a*

consideration as a useful model, for a greater number of respondents (113 = 17.9%), which was indicated when they selected it as *one of their top three choices* in treating the vignette couple.

Identification of Transference and Countertransference (Item #11b):

On Item #11b (n = 642), where respondents were asked to identify three key issues in terms of what was going on with the vignette couple, issues related to transference and countertransference were being sought in this assessment of problem identification. There were 3 possible correct/accurate answers for this question, and therefore, each respondent had 3 opportunities to achieve points for these accurate responses. There were 67 (3.5%) accurate identifications of transference and countertransference made, out of a possible 1,926 (3 possible answers x 642 respondents on this item = 1,926). 4 respondents attained all 3 correct; 11 attained 2 out of 3 correct, and 33 attained 1 out of 3 correct. (A total of 48 = 7.5% respondents gave at least one accurate example of transference or countertransference.) Out of a possible 1,926 (3 possible answers x 642 respondents on this item) opportunities for these respondents to identify transference and countertransference, only 67 identifications of these concepts were made, indicating difficulty.

Respondent's Most Influential Source of Data (Item #11c):

On Item #11c (n = 629), the respondent was asked to identify and rank order the three most influential sources of data that he/she used to determine his/her response on item #11b (i.e. in his/her assessment of the three key issues for the client couple in the vignette). The largest number of couples counsellors (67.1%) selected "content" as one of their top three choices. Among the three sources of influential data that were determined by this researcher to be the best/correct answers (for purposes of this research study), 39.7% respondents selected "therapist client interaction" as one of their top three choices, 34.7% selected "theoretical model", and 9.7% chose "personal data (subjective data)".

Scoring on the Key Indices – Where the Theoretical Meets the Clinical Application:

Items on the questionnaire were categorized under various key indices of awareness, acknowledgment, understanding, attitude, overall index, and use/practical application with a maximum possible score out of 10 being assigned for each index. Additionally, a maximum possible score out of 10 was assigned to the overall index which was composed of the indices for awareness, acknowledgment, understanding and attitude. The index of use was scored both separately and distinctly, as an indicator of the demonstration of practical application (on the vignette) of (theoretical and conceptual knowledge of) the psychoanalytic model, and transference and countertransference (For details on the combination of items which compose the scoring for each variable, see Appendix B, Coding and Scoring.)

Table Z26

Mean Scoring on the Key Indices

	Awareness	Acknowledgment	Understanding	Attitude	Overall Index	Use
Score	5.56	6.12	5.21	6.88	5.94	1.50
S.D.	1.70	2.54	1.92	1.88	1.31	1.24

Table Z26 outlines the mean scores on the key indices for this sample of couples counsellors. Overall, this sample of couples counsellors scored "Average" in terms of their awareness and understanding, relatively "Average-High" on acknowledgment and attitude and "Average" on the overall index and (very) "Low" on use which is their demonstrated application of transference and countertransference (on the vignette) as well as their consideration of the psychoanalytic model. A much larger percentage of those respondents who were psychoanalytically oriented were among the highest scoring respondents on the key indices. Conversely, a much smaller percentage of those respondents who were psychoanalytically oriented were among the lowest scoring respondents on the key indices. (Table Z27)

Table Z27

Couples Counsellors who Scored High or Low on the Key Indices

Index	%	Total (n = 654)		Psych. 1st (n = 38)	%	Psych. top 3 (n = 109)	%
Awareness	80	59	9.0%	8	21.1%	17	15.6%
Acknowledgment	80	165	25.2%	20	52.6%	47	43.1%
Understanding	80	66	10.1%	2	5.3%	9	8.3%
Attitude	80	183	28.0%	23	60.5%	54	49.5%
Overall Index	80	27	4.1%	6	15.8%	13	11.9%
Overall Index	70	133	20.3%	21	55.3%	45	41.3%
Use	80	0	0.0%	0	0.0%	0	0.0%
Use	50	24	3.7%	23	60.5%	23	21.1%
Vignette	50	43	6.6%	7	18.4%	14	12.8%
Awareness	40	99	15.1%	3	7.9%	11	10.1%
Acknowledgment	40	129	19.7%	3	7.9%	12	11.0%
Understanding	40	109	16.7%	2	5.3%	12	11.0%
Attitude	40	45	6.9%	0	0.0%	0	0.0%
Overall Index	40	47	7.2%	0	0.0%	2	1.8%
Use	20	512	78.3%	0	0.0%	43	39.4%
Vignette	30	450	68.8%	16	42.1%	60	55.0%

Notes on Table Z27 :

On the top half of this table are statistics regarding respondents who scored a specific percentage or higher/better on the various indices (listed under the first "%" heading). On the bottom half of the table are statistics regarding respondents who scored a specific percentage or lower/poorer on the various indices. The "Total" column displays the number of respondents who attained a score above that which is stated in the first "%" column above. The column with the heading "Psych. 1st" displays the number of respondents who chose the psychoanalytic model as their first model of choice (in #9a) and who attained a score higher than that which is stated in the first "%" column. The column with the heading "Psych. top 3" displays the number of respondents who chose the psychoanalytic model as one of their top three choices (in #9a) and who attained a score higher than that which is stated in the first "%" column. Of interest to note is that while all respondents scored "Low" on the Index of Use/Practical Application, 24 (3.7%)

respondents attained a score of at least 50% and of these respondents, 23 had placed the psychoanalytic model as their first model of choice in Item #9a. Also of interest to note is that the 1 other respondent who was in this scoring range had chosen the emotionally-focused model as his/her first model of choice. Since the emotionally-focused model is considered to be psychodynamic/psychoanalytic in nature, this may explain why the respondent who selected this model of choice as his/her theoretical orientation scored in the same range as those who had selected the psychoanalytic model.

Appendix AA: Identification and Classification of Questionnaires Mailed Back from Respondents

Response Rate (Detailed):

(Breakdown)

A total of 7,100 questionnaires were mailed out to the entire sample of potential respondents/participants, and 1,401 respondents/participants mailed back their questionnaires, for a response/return rate of 19.7%. It may be of interest to note that 333 questionnaires (which constituted 23.8% of the total mailed back) were returned on or before April 16th which was the earliest due date/deadline indicated in order for respondents to be entered in the Bonus Early Bird Draw, and 142 (10.1%) were returned on or before April 23rd which was the second earliest due date/deadline specified for respondents to be entered in the Early Bird Draw. These draws/raffles had been designed as incentives to encourage an earlier response rate. The remaining questionnaires (926 = 66.1%) were received by April 28th, the last due date/deadline given for respondents to return their completed questionnaires and completed accompanying order forms for their absolutely free gift (a choice of either professional cards or professional/personalized stationery).

It may also be of interest to note that not all respondents who returned their completed questionnaires also included a completed order form for their absolutely free gift (as a "thank you" for responding to the survey/questionnaire). Of the 1,401 respondents who mailed back their questionnaires, 959 (68.5%) included their completed "free gift" fliers/order forms as well. (Of this total number of 1,401 mailed back questionnaires, if the Non-Participating (22), Duplicates (19), and Undeliverable/"Return to Sender" (50) are not included, then the sample of returned questionnaires is 1,310 and the number of respondents who had chosen to order a free gift is 959 of the 1,310 total respondents (73.2%). Several respondents included written comments, thanking the respondent for engaging in this "important research study that needs to be done" and "allowing me to participate"; these respondents wrote that they were "pleased to

participate in this study and do not wish to receive the gift. Thank you anyway." The previously quoted comment from one respondent is representative of others who wrote similar remarks and included them with their mailed back completed questionnaires.

These respondents seemed pleased to be participating in this research study and appeared to value the merit of this study; their participation in it was a result of their interest in the research topic and/or the findings (since several respondents who opted not to order their complimentary gift did request a copy of the findings upon completion of the study). Several respondents also wrote that they appreciated the researcher's offer of a "thank you" gift which was considered to be "thoughtful", "a great idea", and "a very innovative and good incentive". Only two respondents who returned their completed questionnaires indicated that they "resented" the idea of a gift since this "felt commercial". Two respondents who chose not to participate in this research study contacted the researcher by telephone to inform the researcher of their decision and added that they "also did not like the idea of an incentive gift since it is too commercial and does not belong with a research study." Overall, the response to the incentive gift was positive and affirming.

Several respondents had contacted this researcher by telephone or e-mail to inquire about the possibility of mailing back their questionnaires a few days later due to a variety of reasons including: 1) the respondent had requested a replacement questionnaire earlier since his/her initial one had not been received or had been received and misplaced, and there was the necessity to allow for the additional time for the completed replacement questionnaire to be mailed back, 2) illness, 3) death in the family, 4) realization that the due date/deadline would be missed unless researcher would allow additional time for respondent to complete and mail back questionnaire or 5) other. Four respondents contacted the researcher to apologize for sending back their completed questionnaire late, and explained that additional time had been required to "review theories prior to completing the questionnaire and then carefully answer the questions". Each of these individuals commented that the questionnaire had "made them think

about the various theoretical models and also about my own practice...what I do and how I do it." The researcher allowed an additional two weeks within which the remaining questionnaires could be returned, and sent a note via e-mail message (to those potential respondents for whom there was an e-mail address) to announce that the due date/deadline for completed questionnaires to be returned had been extended to May 16th. A special stamp was designed and purchased by the researcher to place on blank replacement questionnaires (which had been requested by several respondents) which clearly reminded the respondent that the questionnaire needed to be completed and mailed back by the new date of May 16th.

Of the 7,100 questionnaires that were sent out, 1,401 (19.7%) were mailed back by respondents, and 941 (67.2%) of these were determined to be "useable", in terms of a representative sample of clinical social workers and other non-Social Work practitioners. The breakdown for the total number of questionnaires mailed/received back (1,401) can be described in terms of the response rate for the three professional organizations: the O.A.M.F.T., O.A.S.W. and O.C.S.W.S.S.W. respectively. Overall, 168 O.A.M.F.T. members were identified from the total number of respondents (1,401) for a response rate of 12% among O.A.M.F.T. members; 33 O.A.S.W members were identified from the total number of respondents, for a response rate of 2.4% among O.A.S.W. members; 1,200 O.C.S.W.S.S.W. members accounted for the remainder of the respondents, for a response rate of 85.7% among O.C.S.W.S.S.W. members.

Of the 941 completed questionnaires which were determined to be "useable" as the representative sample of respondents/participants for this research study, 143 O.A.M.F.T. members were identified from the total sample, for a response rate of 15.2% for O.A.M.F.T. participants; 25 O.A.S.W. members were identified from the total sample, for a response rate of 2.7% for O.A.S.W. participants; 773 O.C.S.W.S.S.W. members (773/941) accounted for the remainder of the sample, for a total of 82.1% among O.C.S.W.S.S.W. participants.

The 1,401 total questionnaires received are accounted for as follows: 941 (67.2%)

Clinical/Useable, 22 (1.6%) Non-Participating (which include Blanks/those questionnaires mailed back blank), 19 (1.4%) Duplicates, 50 (3.6%) Undeliverable/"Return to Sender", 226 (16.1%) Non-Clinical, 143 (10.2%) Rejected/Non-Useable, and 53 (3.8%) Psychoanalytically-oriented respondents.

Clinical social workers or other helping professionals considered to be clinical therapists/counsellors were classified as "clinical" if they currently engage in practice with clients, and indicated this as their response to Item #3a) on the questionnaire, stating that he/she is "presently working as a clinical social worker/therapist/counsellor". The respondent would confirm this response by his/her answer to Item #5a) where he/she is asked to indicate "the response that most accurately describes your current workplace". As a further confirmation that the respondent is a clinical social worker/therapist/counsellor, he/she was asked to specify or identify "the majority of clients/patients" whom he/she "currently treats" in his/her "clinical practice" on Item #6a), i.e. individuals, couples, families, groups, other.

The total sample of respondents was divided into Clinical and Non-Clinical social workers/therapists, with the Clinical practitioners totalling 941 (67.2%) of the overall sample (1,401) and the Non-Clinical totalling 226 (16.1%). The focus for this research study is the population of Clinical social workers and non-social workers who are therapists/counsellors; specifically those who treat couples, and who are currently employed in this capacity. Therefore, the total sample of received questionnaires needed to be divided, in order to separate the Clinical from the Non-Clinical practitioners. The main differentiating factor that distinguishes the Non-Clinical practitioners (who would be excluded from this study) from those respondents who were considered excluded for other reasons, is that these identified Non-Clinical practitioners are currently employed in some professional capacity, but not in the area of clinical Social Work. The number of respondents who were excluded from the research sample for "other reasons" included those respondents who were students, retired, etc.

A delineation of the non-Clinical group which comprised 16.3% of the total sample can be

explained as follows: 55 (24.1%) Social Agency, 35 (15.4%) Government worker, 27 (11.8%) Child Welfare/Children's Aid, 27 (11.8%) Hospital setting, 26 (11.4%) Community Care/Nursing Home/Home Care, 18 (7.9%) Family Services, 17 (7.5%) Other, 12 (5.3%) Academic (Research, etc.), 7 (3.1%) Supervisors and 4 (1.8%) Organizational setting. These respondents had indicated "No" when asked whether they are "presently working as a clinical social worker/therapist/counsellor" (Item #3a) and clarified their current workplace/employment setting in a later question (Item #5a). It is interesting to note that most practitioners who are employed in Child Welfare/Children's Aid settings (as indicated in Item #5a) do not perceive themselves as "presently working as a clinical social worker/therapist/counsellor" (indicating "No" in Item #3a); in other words, these practitioners do not perceive nor identify themselves as clinical social workers.

Non-participating respondents (22 = 1.6%) were identified as those individuals who had chosen not to participate in this study. Several indicated their choice by returning their blank questionnaire or a blank questionnaire with their comment.

Appendix BB: Inter-Rater Reliability

Inter-Rater Reliability for the Questionnaire Open-Ended Questions Related to the Vignette:

Prior to our sample of acceptable or useable questionnaires being reviewed and scored (in terms of points being given for correct or accurate responses), two raters were trained to code and score the open-ended questions on the questionnaire, which were associated with the vignette. Items #12a, #12b, #16a, and #16b were the open-ended questions requiring inter-rater reliability, with 80-85% reliability considered to be adequate.

The first half of #12a asked the respondent whether he/she had any subjective reactions (e.g. thoughts and feelings) to the couple in the vignette, and the second half of this question asked the respondent to describe what his/her subjective reactions were to the couple. The first half of #12b asked the respondent whether his/her subjective reactions would influence his/her response or interaction with the couple in the vignette, and the second half of this question asked the respondent to describe how his/her subjective reactions would influence his/her response or interaction with the couple. Item #16a asked the respondent to comment on any subjective reactions that he/she may have had to the therapist's approach and attitude to the clients/the couple (in the vignette), and #16b asked the respondent to comment on any subjective reactions that the therapist may have toward these clients/this couple.

Two individuals were trained as raters in four training periods over an intensive and comprehensive two-week period, with the emphasis on the Psychoanalytic model, its main tenets and its significant concepts. An overview of the concepts of transference and countertransference was presented to the raters as well as how these concepts were relevant to the open-ended questions: the raters were instructed about this prior to their reviewing any of the questions answered by the respondents. The researcher then presented examples of answers to the four open-ended questions (that had been pre-selected from actual completed questionnaires) and

demonstrated how these questions would be coded as accurate or inaccurate responses. The raters were given an opportunity to ask questions for clarification. Both raters were also given copies of Psychoanalytic Terms and Concepts (Moore & Fine, 1990) and The Primer of Object Relations Therapy (Scharff & Scharff, 1995) to be employed as additional references or resources for clarification or confirmation, in addition to the researcher making herself available to both raters during this part of the training and practice process as well as during the continued process of coding and scoring all of the questionnaires for data entry.

The two individuals who were chosen to be raters were selected on the basis of their intellect, conscientious and trustworthy nature, and their interest in this research. Both raters were not employed nor involved in the Social Work nor Psychology field, and this was viewed as an advantage. Neither rater had any preconceived notions or hypotheses regarding this research, nor did either have a theoretical orientation. Both raters were taught about the Psychoanalytic model, its main tenets and the relevant concepts, and the end result was their strong understanding of Psychoanalytic theory and the conceptual framework, including an impressive capability to correctly determine whether or not a respondent had accurately responded to the open-ended questions presented.

After the training process, each rater was given 20 questionnaires for him/her to code and score the four open-ended questions that had been responded to on each questionnaire (i.e. each rater scored 20 sets of the four questions). The coding and consequent scoring of each response as correct/accurate or incorrect/inaccurate was then matched with those of the researcher who had also coded and scored these same responses; this process was done in order to determine good reliability. The first time, 80% and 85% was attained by each rater respectively, and the second time, 85% and 90% was achieved. While the reliability was determined to be good at this point, nevertheless two additional rounds took place where the questions determined to be most challenging were scored, to both ensure good reliability and to try to improve on the high percentage of reliability already attained by both raters. On the third round, both raters attained

90% and 95% reliability, and on the fourth and final round, both raters attained 95% reliability between their scoring of the more challenging questions and that of the researcher. As demonstrated, the inter-rater reliability was very good among the researcher and the two raters, on the open-ended questions.

Appendix CC: Histogram and Probability Plot for Linear Model for Couples Counsellors

Figure CC1

Histogram of Couples Counsellors

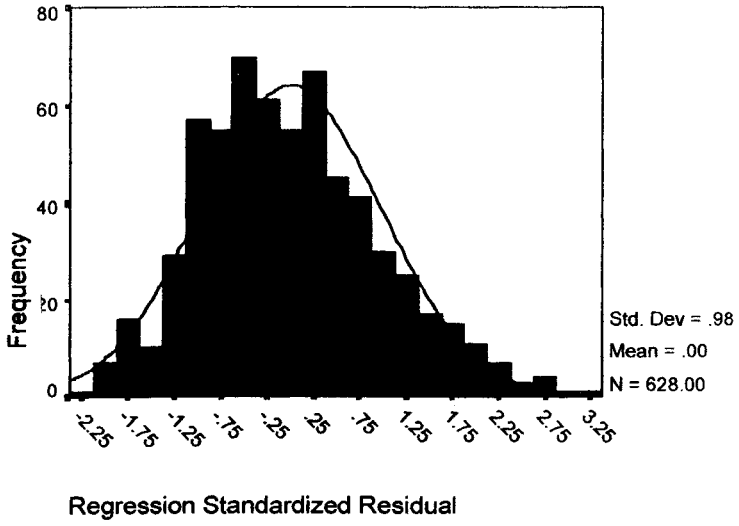
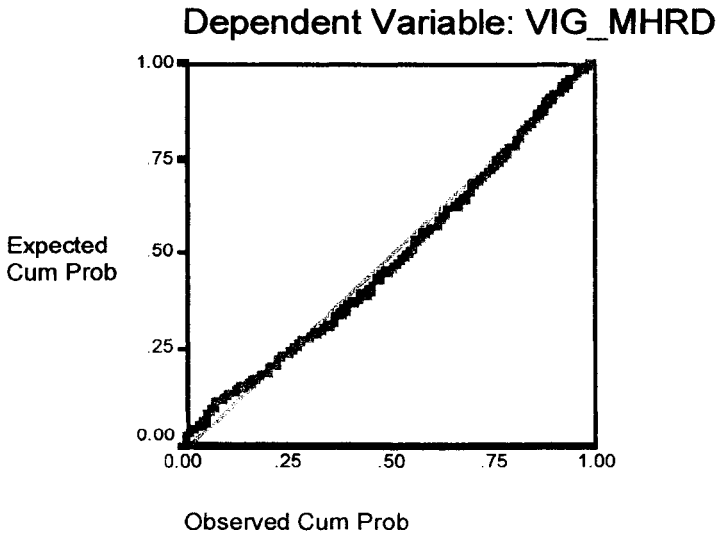


Figure CC2

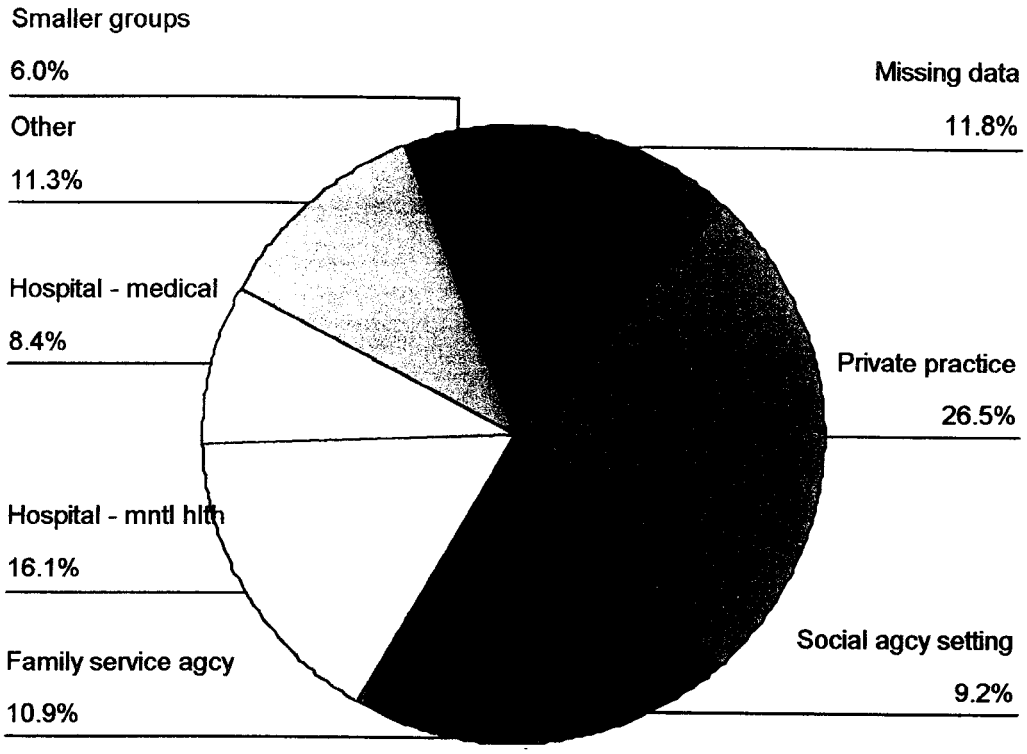
Probability Plot of Couples Counsellors.



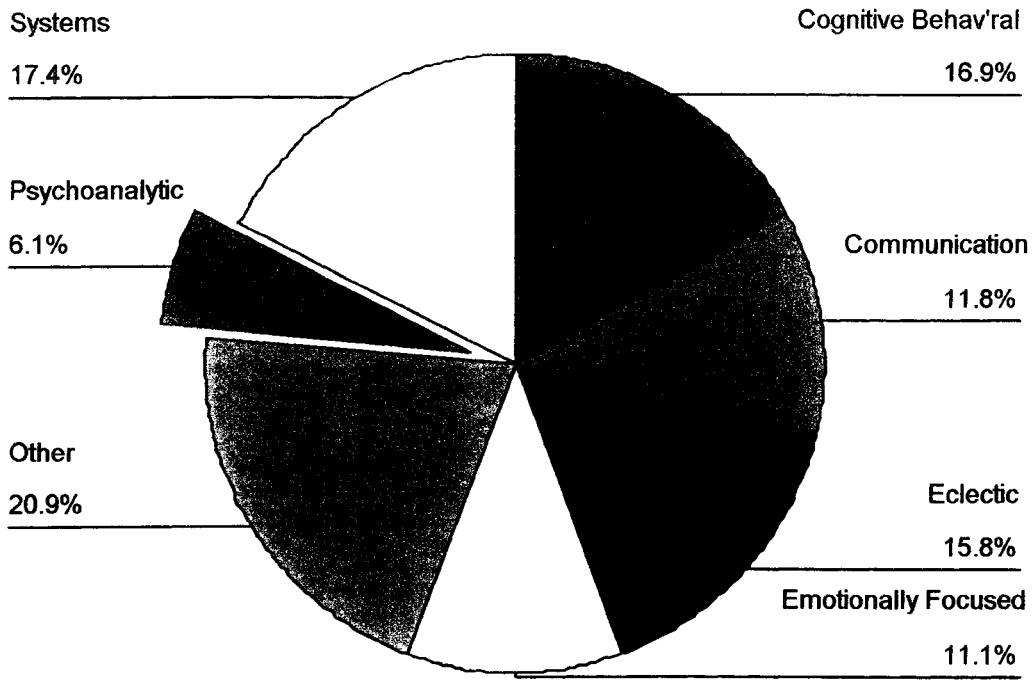
Assumptions:

Both the normal probability plot and a histogram of the data, indicated the standard assumptions for the linear model had been satisfied. The Durbin-Watson of 1.783 indicates independence of the residuals. A scatter plot of the residuals and predicted y shows no discernable pattern, indicating homogeneity of variance. The Casewise diagnostics indicated 8 outliers/residuals. The following are the Standard Deviations for these very large residuals: 3.19, 3.21, 3.25, 3.30, 3.34, 3.61, 3.85, 4.31 These were removed from the sample. Twice the mean Centred Leverage value was (.011 x 2 =) .022. No large influential observations were found.

Appendix DD: Pie Chart of Current Employment Settings for Couples Counsellors
(Item #5a)



Appendix EE: Pie Chart of Theoretical Orientations for Couples Counsellors
(Item #9a – First Choice)



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