Managing Negative Countertransference Utilizing an Integrated Counselor Mindfulness Training for Counselors Working with Children Exhibiting Externalized Behaviors

Jessie D. Guest

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MANAGING NEGATIVE COUNTERTRANSFERENCE UTILIZING AN INTEGRATED COUNSELOR MINDFULNESS TRAINING FOR COUNSELORS WORKING WITH CHILDREN EXHIBITING EXTERNALIZED BEHAVIORS

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ABSTRACT

Using a multiple-probe, single case research design, this study investigated the effects of an integrated mindfulness intervention on counselors’ negative countertransference while working with children exhibiting externalized behaviors in session. More specifically, this study utilized a two-pronged intervention including mindfulness practices as well as the theoretical tenets of relating to children to assist counselors in managing negative countertransference as measured by the Countertransference Management Scale (Perez-Rojas, et al., 2017), reducing negative countertransference feelings as measured by Therapist Appraisal Questionnaire (Cooley & Klingler, 1989; Fauth et al., 1999), and improving the child’s perception of the counselor as measured by Young Child Session Rating Scale (Duncan et al., 2006). The results of this study provided further support for using a two-pronged approach of mindfulness and theory to best manage countertransference and reduce countertransference feelings for counselors working with challenging populations.

Keywords: negative countertransference, difficult clients, mindfulness
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CHAPTER ONE: INTRODUCTION

Overview

In light of the strong emergence of common factors in counseling research and clinical practice, maintaining mechanisms that increase the likelihood of positive client outcomes is of the utmost importance. Common factors in counseling are the similarities found among most or all therapies that have been tied to positive client outcomes (Norcross, 2011). Three of the common factors mentioned by Norcross are the therapeutic alliance/relationship, client characteristics, and counselor characteristics. The therapeutic alliance or relationship between client and counselor is imperative to the change process (Bordin, 1979; Landreth, 2012; Rogers, 1957) and is noted as the key common factor among counseling theories (Norcross, 2011). In addition, the counselors’ personal reactions or feelings about the client, as well as how these reactions are handled by the counselor, are essential to counseling effectiveness (Fauth & Hayes, 2006; Strupp, 1980) because these feelings may influence perceptions of genuineness in the counseling relationship. Carl Rogers (1957) recognized a way of “being”, both in session and out of session, that acknowledges congruence as an essential condition for the counselor. Additionally, Virginia Axline and Gary Landreth, two pioneers of child-centered play therapy (CCPT), also focused on the importance of “self” of the counselor during session as the counselor is noted a key therapeutic tool (Axline, 1969; Landreth, 2012). Although the importance of these three common factors is well known among the
counseling profession, counselors still struggle with negative attitudes/feelings towards clients as it is often difficult for counselors to admit due to the dissonance admission creates between their role and view of being a helping professional (Kottler & Uhlemann, 1994). Additionally, working with challenging clients who elicit stress responses within the counselor may be difficult to present acceptance, positive regard, and empathy during every session (Folkman, 1984).

**Statement of the Problem**

Counseling can be stressful for clinicians who work with challenging populations (Hastings, 2002). Due to the lack of literature and time spent in the counseling profession on managing negative countertransference or negative feelings towards clients, counselors and counselors-in-training are struggling with acknowledging, accepting, and working through their negative feelings; thus, leading to inappropriate treatment approaches (Guest et al., *In review*; Linn-Walton & Pardasani, 2014). Linn-Walton and Pardasani (2014) and Guest and colleagues (*In review*) conducted qualitative studies involving psychologists, social workers, and beginning counselors who admitted feelings of dislike or other negative feelings towards clients. The helping professionals reported engaging in the following “coping” skills: (a) blaming the client for contributing to their feelings of dislike; (b) labeling clients as difficult to work with; (c) minimizing empathic responses to clients; (d) instilling fear in clients; (e) using intimidation to control client’s behaviors; (f) struggled not being control; (g) viewed the client as a “bully”; (h) shortened sessions times; and (i) believed the client needed to get his “butt” beat. Therefore, it appears that more training may be helpful in managing negative countertransference and strengthening the therapeutic relationship.
Challenging populations can include working with children as children communicate differently than adults due to varying developmental levels and cognitive processing (Landreth, 2012). Often, children use behaviors as a way of communicating and children who have endured a significant life event (trauma, change, loss, etc…), may exhibit externalized behaviors as a way of communicating their feelings or needs (Gerson & Rappaport, 2012). However, it appears that the behaviors children use for communication are the same behaviors that induce high levels of counselor stress leading to counselors engaging in negative thoughts and feelings towards their clients (Keil & Price, 2006; Linn-Walton & Pardasani 2014). Consequently, the children and clients that need the most help are often not receiving the help they need due to counselors’ frustration and inability to provide empathy, positive regard, and acceptance needed for positive client change. Therefore, the purpose of this research was to investigate the effect of an integrated counselor mindfulness training on negative countertransference and therapeutic alliance for counselors working with children exhibiting externalized behaviors.

**Purpose of the Study**

The purpose of this research study was to investigate the effect of an integrated counselor mindfulness training on negative countertransference for counselors working with children exhibiting externalized behaviors. Specifically, the integrated counselor mindfulness training utilized in this study included; (a) mindfulness training and practice (Kabat-Zinn, 2013) and (b) education on the theoretical tenets of relating to children (Landreth, 2012). The goals of this study were to add to the literature on countertransference management and to create an intervention or training to assist
counselors while working with children exhibiting externalized behaviors in managing countertransference experiences impacting their work. This study provides information on the effects of an integrated counselor mindfulness training on reducing negative countertransference. Consequently, the results of this study provided a small causal relationship between the integrated counselor mindfulness training and countertransference feelings.

**Theoretical Framework**

This investigation was built upon two main concepts: (a) Countertransference/Negative Countertransference and (b) Mindfulness. However, to fully understand both constructs and their importance; elements of person-centered Theory and child-centered play therapy need to be addressed. Additionally, understanding how working with stressful populations such as children exhibiting externalized behaviors influence both constructs will be discussed.

**Person-Centered Theory**

According to person-centered theory and child-centered play therapy, the person of the counselor is an essential component to effective therapy (Landreth, 2012; Norcross, 2011; Rogers, 1957) as the core beliefs of both theories include the belief that individuals/clients have the capacity towards continual positive growth and the counselor needs to remain fully present, open and accepting, congruent, genuine, empathic, and display unconditional positive regard for the client at all times (Landreth, 2012; Rogers, 1957). The therapeutic relationship is considered the vehicle of change and anything that impacts the relationship (positively or negatively) is influential in client change. For example, countertransference experiences that the counselors are unaware of can
negatively influence the relationship and it is viewed as the counselors’ job to do what is needed to acknowledge and attend to countertransference triggers, feelings, and behaviors (Bohart & Watson, 2011). Therefore, mindfulness practices to bolster self-awareness, self-integration, and self-regulation can be extremely beneficial for counselors and client progress. Consequently, the therapeutic relationship and all components influencing the relationship are essential in counseling effectiveness and client progress.

**Therapeutic Relationship**

The therapeutic relationship (TR), also referred to as the therapeutic alliance, is pivotal in positive client outcomes across theoretical orientations (Norcross, 2011). Researchers have proven that the therapeutic relationship accounts for 30% of the client’s change in therapy (Norcross, 2011), illustrating the level of importance of the client-counselor relationship in all counseling theories. The therapeutic relationship can be defined in various ways; however, Norcross (2011) and Bordin (1979) describe the therapeutic relationship as the bond between the client and counselor including goal agreement and collaboration on tasks. This therapeutic bond includes counselor genuineness and therapeutic presence in terms of empathy, positive regard, acceptance, and encouragement (Rogers, 1957) and is noted as the change agent in person-centered theories.

**Therapeutic Presence**

Researchers have noted the importance of the therapeutic relationship; however, the therapeutic relationship cannot be the strong change agent that it is without the counselor being fully present and genuine (Rogers, 1957). Therapeutic presence can be defined as bringing the counselor’s whole self into session by simultaneously being fully
in the moment physically, emotionally, cognitively, and relationally (Geller & Greenberg, 2002) and is a way of being fully engaged in session with the client (Geller, 2013). Presence also involves the ability to remain grounded as a counselor while receiving the verbal and bodily expressions of the client’s in-the-moment experience (Geller & Greenberg, 2002). An awareness of self allows the present counselor to be attentive and sense how his/her responses are influencing the therapeutic alliance and the client’s therapeutic processes (Geller & Greenberg, 2002). The client is also influenced by how the counselor reacts to and interacts with the client in session, therefore, influencing the therapeutic relationship. Providing a safe and open environment for clients to share, experience vulnerability, and grow is paramount in the counseling profession and is often done through the strength of the therapeutic relationship but this cannot be done if the counselor is not authentic or genuinely illustrating acceptance, positive regard, and empathy (Rogers, 1957). Regardless of therapeutic technique, approach, or orientation, the counselor’s ability to remain in-the-moment or be present, contributes to the client’s experience and impacts treatment outcomes (Marshall et al., 2003; Shirk & Karver, 2003). However, client characteristics, client behaviors, counselor stress, and other triggers such as countertransference experiences combat counselors’ abilities to remain therapeutically present.

**Countertransference**

Feelings or thoughts that interfere with the counselors' ability to be present and genuine in session can be referred to as countertransference (Kiesler, 1982). The definition and conceptualization of countertransference have been continuously changed and shaped since Freud's conception of the term. Freud developed the idea of
countertransference as the unconscious reactions experienced by the counselor towards his/her client (Freud, 1910). Corey, Schneider-Corey, and Callanan (2007) expanded Freud’s definition to include the counselor’s experience of inappropriate emotions or irrational thoughts towards the client, including losing objectivity with the client. Additionally, family theorists, more specifically Bowen Family Systems theorists, focused on the client’s influences stemming from previous and current relationships and issues of differentiation, thus, illustrating the potential origins of countertransference (Bowen, 1976). However, the most accepted understanding of countertransference is a combination of multiple conceptualizations of countertransference describing it as the process in which the counselors’ inevitable, unresolved conflict leads to misdirected feelings towards the client, that may have been triggered by the counseling content, client’s personality, or even client’s appearance, that can either help or hinder the therapeutic relationship and client outcome depending on counselor’s awareness (Gelso & Hayes, 2007).

Feelings of countertransference can be both positive or negative and are considered inevitable since counselors both consciously and unconsciously experience feelings while working with clients as people are relational beings and carry their own past experiences into therapy (Gelso & Hayes, 2007). However, according to Freud (1959) and researchers following him (Bandura, Lipsher, & Miller, 1960; Cutler, 1958; Friedman & Gelso, 2000; Forester, 2001; Gelso, Fassinger, Gomez, & Latts, 1995; Hayes, Riker & Ingram, 1997; Latts & Gelso, 1995; Ligie’ro & Gelso, 2002; Mohr, Gelso & Hill, 2005; Myers & Hayes, 2006; Nutt-Williams &, Fauth, 2005; Peabody & Gelso, 1982; Robbins & Jolkovski, 1987; Rosenberger & Hayes, 2002; Yeh & Hayes, 2011),
managing countertransference is essential as the counselor should not put his/her feelings onto the client as the counselor may lose objectivity due to over connecting with or having negative feelings towards the client (Corey, Schneider-Corey, & Callanan, 2007). In addition to losing objectivity, countertransference can also lead the counselor to engage in counter-therapeutic behaviors such as inappropriate confrontation, unresponsiveness, and criticism (Marshall, et al., 2003). Distortion of clients’ personalities and client prognosis can also be influenced by countertransference (McClure and Hodge, 1987). Additionally, if countertransference goes unchecked or undealt with, countertransference manifestations (counselors exhibited reactions) can occur in session, harming the therapeutic relationship (Strupp, 1980).

**Negative Countertransference**

Although the concept of countertransference includes both positive and negative feelings, there is a gap in the counseling literature on counselors working with clients they dislike. Countertransference is addressed in supervision within the counseling profession as self-awareness and the emphasis on the counseling relationship is founded within CACREP’s (CACREP, 2016) eight core areas as well as the first section of the American Counseling Association (ACA) *Code of Ethics* (2014). However, specifically focusing on negative countertransference and counselors’ negative feelings towards clients is a rarity within counseling literature (Guest et al., *In review*; Linn-Walton & Pardasani, 2014; Shapiro, 1974; Strupp, 1958). However, there are studies that have identified specific client groups that appear to trigger counselors’ countertransference such as children exhibiting externalized behaviors (Guest et al., *In review*), clients diagnosed with Borderline Personality Disorders (Liebman & Burnette, 2013), clients
diagnosed with Narcissistic Personality Disorders (Tanzilli, Muzi, Ronningstam, & Lingiardi, 2017), and clients that induce high levels of counselor stress in general (Fauth & Hayes, 2006). Due to the notion that counselors are “helpers” and counselors work in a “helping profession”; it is challenging for counselors to admit negative feelings towards clients as it is contradictory to how counselors “should” feel (Kottler & Uhlemann, 1994). However, if negative feelings towards a client continue to go unchecked and not managed by the counselor, inappropriate treatment may occur (Strupp, 1980). The present study focused on a specific population; counselors working with children exhibiting externalized behaviors as these behaviors can be due to various diagnoses or environmental factors yet they all still induce high rates of counselor stress.

**Externalized Behaviors**

It is easier to like a client or exhibit positive regard for a client when he/she demonstrates behaviors the counselor deems acceptable or less stressful (i.e. on time, listens, isn’t threatening, makes progress, etc…). However, it becomes more challenging for counselors to show positive regard, empathy, and acceptance when the client throws things, breaks things, threatens, is oppositional, yells, or engages in other behaviors that induce stress on the counselor (Hastings, 2002). Externalized behaviors can be defined as any behavior that violates societal norms, is disruptive, may involve stealing, or property destruction and are typically explicit and can include harm to others (Keil & Price, 2006; McCart & Sheidow, 2016). However, there is also a correlation between exposure to challenging or disruptive behaviors and stress (Hastings, 2002). Additionally, when a counselor considers a situation to be stressful, he/she also experiences feelings of sadness, anger, and other negative emotions (Folkman, 1984); therefore, making it more
difficult to remain objective and to develop and maintain a strong therapeutic alliance. Although it may be challenging, researchers report that developing and maintaining a positive therapeutic relationship is of the utmost importance when working with children exhibiting externalized behaviors (Marshall et al., 2003). Therefore, engaging in practices to assist in counselor self-awareness and self-regulation, like mindfulness practices, may assist in managing countertransference experiences.

**Mindfulness**

Kabat-Zinn (1990) described mindfulness as a process engaging in a specific quality of attention to the here-and-now or present moment. Mindfulness approaches are effective in promoting emotional regulation of the brain including areas of the brain involved in attuned communication, emotional stability, empathy, insight, and flexible responses (Davis & Hayes, 2011; Siegel, 2007). Mindful breathing or diaphragmatic breathing calms the body’s stress responses and allows individuals to see things more clearly and increase objectivity (Siegel, 2007). In addition, mindful breathing, meditation, and other mindfulness interventions enhance self-regulation allowing the individual to acknowledge thoughts, feelings, and sensations through the lens of nonjudgement and acceptance (Bishop et al., 2004). Mindfulness practices also assist with minimizing stress responses of anger, fear, and avoidance (i.e. negative countertransference behaviors) when feeling exhausted, threatened, or distracted (Napoli, 2001). However, Hayes, Gelso, and Hummel (2011) reported that mindfulness strategies alone are not as effective in managing countertransference as a combined approach including both mindfulness approaches and an educational/theoretical framework. Therefore, using an integrated theoretical and mindfulness training that includes elements of mindfulness and the
theoretical tenets of relating to children therapeutically improves counselor’s ability to accept and manage negative countertransference and provide appropriate and needed care to challenging child clients.

**Operational Definitions of Terms**

Due to the multifaceted nature of this study and the use of constructs with fragmented definitions and various understandings, there are a number of terms that may need further description. To ensure clarity and meaning of specific terms used throughout the study; the constructs are defined.

**Therapeutic Relationship**

For this study, the combined definitions of Bordin (1979) and Norcoss (2011) were used to describe the therapeutic relationship, an essential element to the counseling process, as the bond between the client and counselor including goal agreement and collaboration on tasks.

**Countertransference**

Countertransference has been defined in multiple ways since Freud’s definition of the unconscious reactions experienced by the counselor towards his/her client (Freud, 1910). Corey, Schneider-Corey, and Callanan (2007) expanded Freud’s definition to include the counselor’s inappropriate emotions or irrational thoughts towards the client as well as a loss of objectivity. However, for this study, countertransference was defined using Gelso and Hayes’s (2007) definition of countertransference; countertransference is the process in which the counselors’ inevitable, unresolved conflict leads to misdirected feelings towards the client that may have been triggered by the counseling content,
client’s personality, or even client’s appearance, that can either help or hinder the therapeutic relationship and client outcome depending on counselor’s awareness.

**Negative Countertransference**

Negative countertransference (NC) is considered under-involvement with the client including negative feelings or reactions the counselor experiences towards the clients (i.e. avoidant behavior, withdrawal, criticism, anxiety, anger, disgust, etc.) (Friedman & Gelso, 2000). Negative countertransference differs from the general term of countertransference in that NC focuses mainly on negative feelings or reactions instead of any and all inappropriate feelings or reactions towards the client. For this study, Friedman and Gelso’s (2000) definition of NC was used.

**Externalized Behaviors**

As mentioned above, externalized is defined as any behavior that violates societal norms, is disruptive, may involve stealing, or property destruction and are typically explicit and can include harm to others (McCart & Sheidow, 2016; Keil & Price, 2006). For this study, externalized behaviors included the combination of McCart and Sheidow (2016) and Keil and Price’s (2006) definition specifically noting the following client behaviors: hitting, kicking, screaming, throwing things, breaking, ripping and/or tearing items.

**Mindfulness**

Kabat-Zinn (1990), the pioneer of mindfulness practices in the medical field, described mindfulness as a process of adhering to the quality of attention to the here-and-now or present moment. Engaging in mindfulness practices minimizes stress responses of negative countertransference behaviors when individuals feel exhausted, threatened, or
distracted (Napoli, 2001). For this study, the definition of mindfulness included elements from Kabat-Zinn’s (1990) definition and Thera’s (1954) describing mindfulness as the process of attending to the here-and-now or present moment with compassion and patience.

**Mental Health Counselor**

For the purpose of this study, the term mental health counselor included only licensed professional counselor interns or associates (LPC and/or LPC-A) who require regular supervision according to the law. All LPC-A’s graduated from a Masters or Education Specialist program in Counseling prior to receiving their LPC-A licensure.

**Research Questions and Hypotheses**

The purpose of this research study was to investigate the effect of an integrated counselor mindfulness training on negative countertransference for counselors working with children exhibiting externalized behaviors. The following research questions were investigated in this study.

**Primary Research Question**

Does an integrated counselor mindfulness training have an effect on counselor’s feelings of negative countertransference while working with children exhibiting externalized behaviors as measured by, *Therapist Appraisal Questionnaire* (Cooley & Klingler, 1989; Fauth et al., 1999)?

**Hypothesis**

The integrated counselor mindfulness training will reduce counselors’ feelings of negative countertransference towards child clients exhibiting externalized behaviors in
session (Hayes, Gelso, & Hummel, 2011; Latts & Gelso, 1995; Robbins & Jolkovski, 1987).

**Secondary Research Question One**

Does an integrated counselor mindfulness training influence the counselor’s ability to manage negative countertransference while working with children exhibiting externalized behaviors as measured by the *Countertransference Management Scale* (Perez-Rojas, et al., 2017)?

**Hypothesis**

The integrated counselor mindfulness training will increase the counselors’ ability to manage negative countertransference while working with children exhibiting externalized behaviors in session (Hayes, Gelso, & Hummel, 2011; Latts & Gelso, 1995; Robbins & Jolkovski, 1987).

**Secondary Research Question Two**

Does an integrated counselor mindfulness training influence the client’s perception of the counseling relationship in session, as measured by the *Young Child Session Rating Scale* (Duncan et al., 2006)?

**Hypothesis**

The integrated counselor mindfulness training will improve the client’s perception of the therapeutic relationship in session (Hayes, Gelso, & Hummel, 2011).

**Research Design**

Single case research design (SCRD), more specifically multiple-probe design, is the experimental design used in this study. SCRD is more often used in educational research but it has started to make a strong emergence into the counseling field. Due to
the rigor of the research design, single case research can assume causality just as other between groups experimental designs as the individual or group that is involved in the study acts as its own control (Kratochwill et al., 2010). Single case research is often used when testing the effectiveness of an intervention if the population of interest is small or specialized where it may be difficult to find large numbers of participants meeting that criteria, and/or if the intervention of interest is novel (Kazdin, 2011). This study fits well with SCRD as the effectiveness of a new intervention on a specialized group of participants was investigated. Similar to multiple-baseline design, the multiple-probe design can be implemented across participants, settings, or interventions. For this study, multiple-probe design across participants was used. In multiple-probe design, the participants are measured intermittently as opposed to every single session like the multiple-baseline design. The intermittent measurement allows for a reduction of testing as it can be strenuous on participants (Kazdin, 2011). Additionally, the consistent testing for this study may lead to diffusion of treatment as continuous testing may lead to increased counselor awareness of countertransference, which was a goal for the training; thus, leading the counselor to make changes or process countertransference differently before the implementing the intervention.

**Research Method**

**Population and Sampling**

Upon IRB approval, participants were solicited via purposive, criterion-based sampling methods (Creswell, 2008), targeting existing relationships with mental health agencies within the northern parts of South Carolina and western parts of North Carolina following strict inclusion criteria parameters. This regional location was selected due to
the professional relationships already established by the researcher, in addition to the need for consistent data collection over a long period of time, and feasibility of implementing the intervention. Data collection and intervention was held in the mental health counseling agency/practice in which the participants worked.

The inclusion criteria for this study included participants who are: (a) beginning mental health counselors (LPC or LPC-A); (b) have one to five years of field experience as a counselor; (c) who worked with children ages three to nine, that exhibit externalized behaviors in session (i.e. hitting, kicking, screaming, throwing/breaking things); (d) who were experiencing negative countertransference behaviors (as measured by The Inventory of Countertransference Behavior (ICB; Friedman & Gelso, 2000), and (e) who reported not having prior experience or training in mindfulness practices. All participants (counselors) consented to participate in the study. Multiple Probe Design, required at least three participants to illustrate a basic effect; however, four participants are recommended (Kazdin, 2011). Therefore, participants were solicited for this study.

Incentives. The counselor participants received $125.00 for their participation in this study. Due to the nature of a single case design study, the length of the study could not be pre-determined; therefore, the participants were asked to engage in a study with no knowledge of an end. In addition, the study required the participants to engage in a 3-hour training, documentation of home practice daily, and engage in constant evaluation/measurement two to three times a week. Incentives for each participant were integral in keeping the participants motivated to continue their participation.
Instrumentation

Demographic Survey

The demographic survey created by the researcher was provided to the counselors and supervisors participating in the survey collecting various demographic information (e.g., gender, age, ethnicity, highest level of education completed, number of years as a counselor/supervisor, number of months working with supervisor/counselor, prior exposure to mindfulness, age and diagnosis of the child clients, etc.). This demographic form was completed prior to beginning the study.

Daily Mindfulness Activity Log

The Daily Mindfulness Log, created by the researcher, was a self-report instrument used to collect and guide the counselor participants through various daily mindfulness exercises used during the intervention phase of the study. The information collected included time of day the mindfulness exercise was practiced, duration of exercise, type of mindfulness exercise, and effects (e.g., reflections, feelings, thoughts, mood, somatic symptoms, etc.) before, during, and after the mindfulness exercise. Additionally, the mindfulness logs and intentional questions about completion in mindfulness practices were used as a retention practice (Leon, Demirtas, & Hedeker, 2007; Rabideau et al., 2014) to enhance participant engagement in the independent mindfulness practices. Although this data provided information to the researcher regarding preference and use of particular mindfulness exercises, the Daily Mindfulness Logs are were also used to assist the counselor participants to remain accountable for continued mindfulness practice.
Post-Intervention Follow-Up Questionnaire

The Post-intervention Follow-Up Questionnaire, created by the researcher, was a self-report questionnaire to collect information and thoughts about the intervention. This data was used to assess the social validity (Kazdin, 2011) of the intervention, a key component of single case research designs. The questionnaire was sent to the counselor participants in the study upon completion of data collection.

The Inventory of Countertransference Behavior (ICB; Friedman & Gelso, 2000)

The Inventory of Countertransference Behavior (ICB) is a 21-item, self-report instrument created for counselor-supervisors to evaluate countertransference among supervisees which is rated on a 5-point scale (1 = to little or no extent, 5 = to a great extent). The ICB has two subscales that evaluate positive CT (e.g., “over-supported the client”) and negative CT behavior (e.g., “rejected the client”). This study only used questions from the negative CT scale. The ICB relates highly to the other measures of CT and CT management, working alliance, and client and therapist attachment and reports a .79 reliability score (Friedman & Gelso, 2000) for both scales. Additionally, the Negative Countertransference Scale reports a moderate to high correlation to factors that are considered “inappropriate counselor behaviors (r = .79) and the authors report a significant convergent validity between the ICB and the Countertransference Index (CT) (r = .43) and significance between the ICB and Countertransference Factors Inventory-Revised (CFI-R) (r = -.62) (Friedman & Gelso, 2000). This scale was completed by the supervisor and counselor participants as a part of the inclusion criteria prior to beginning the study to ensure that the counselor participants in the study were, in fact, engaging in at least one negative countertransference behavior prior to receiving the intervention.
The Therapist Appraisal Questionnaire (TAQ; Cooley & Klingler, 1989; Fauth et al., 1999)

The Therapist Appraisal Questionnaire is a 16-item, self-report, questionnaire utilizing Likert-type items (0 = not at all, 5 = a great deal) measuring three constructs. The TAQ indirectly assesses the counselors’ stress appraisals of a situation or client via the emotions associated with three key constructs. The three constructs measured by the TAQ are the counselor’s feelings of challenge (exhilaration and excitement, etc.), threat (worry and anxiety, etc.), and harm (anger, disappointment, disgust, etc.) as they are experienced in session. Fauth et al. (1999) combined the threat and harm scales to create a negative stress scale which highly correlates with counselor’s ability to manage their self-awareness and value conflicts between clients (Larson, et al., 1992).

The TAQ was sent to the counselors via text through the SurveyMonkey application on the researcher’s phone as the counselors (participants) were expected to complete the survey after each session with the identified clients. Upon completion of the surveys after each session, the researcher then input the data into an excel file for graphing and visual data analysis. Scores were calculated by adding up all scores for each construct with higher scores indicating greater levels of that particular feeling. The threat and harm construct scores were combined, with a score range from 0 – 40, to denote negative countertransference feelings; while the challenge construct remained independent with scores ranging from 0 – 30, to denote more positive feelings of towards the client. This instrument was important in identifying the potential feelings associated with CT triggers and potential manifestations. The TAQ has strong internal consistency (.74-.90) and construct validity (Cooley & Klingler, 1989; Fauth et al., 1999).
**Countertransference Management Scale** (CMS; Perez-Rojas et al., 2017)

The Countertransference Management Scale is a 22-item, self-report, 5-point Likert instrument (ranging from 1 to 5; 1 = Strongly Disagree and 5 = Strongly Agree) measuring the supervisors’ perceptions of the extent in which the counselor exhibits the two elements of CT management in session with clients; (a) understanding self and client and (b) self-integration and regulation. Supervisors completed this inventory at the end of each supervision meeting scoring the counselor in each of the areas noted above. The supervisors received this scale, entered through SurveyMonkey, via email on the days supervision was scheduled with the counselor. The scores were averaged for each subscale with a higher score indicating the counselor having a stronger ability to manage countertransference through either (a) understanding self and client and (b) self-integration and regulation. A total score of Countertransference Management can also be calculated by averaging scores for all 22 items. The internal consistency for the subscales are .93 and .95 as well as it has high convergent and criterion-related validity between the Countertransference Factors Inventory (CFI, Latts, 1996) and counselors effectiveness as rated by the supervisor. (Perez-Rojas et al., 2017).

**Young Child Session Rating Scale** (YCSRS; Duncan et al., 2006)

This single-question, self-report scale measured the client’s perspective of the counseling relationship using four pictures of faces ranging from happy, unsure, sad, a blank face for the child to draw in their own faces for the child to indicate their perception of their relationship with the counselor. Internal consistency of the Session Rating Scale (SRS) for adults is reported at .88 (Duncan, et al., 2003) which is similar to the Child Session Rating Scale’s reliability and consistency (Duncan, et al., 2006). However, the YCSRS does not have any psychometric prosperities but is a useful way to engage young children regarding their
assessment of the counselor and their experience. With the help of another adult in the agency, the child clients of the counselors/participants completed this scale by pointing at a face one time each week and the scale was scanned and sent to the researcher via email each week.

**Data Collection**

Multiple-probe design does not require each participant to engage in continuous measurement every session (Kazdin, 2011). For this study, all participants completed the TAQ (Cooley & Klingler, 1989; Fauth et al., 1999) after every session with the identified clients until baseline stability was established. The supervisors completed the CMS (Perez-Rojas, et al., 2017) after every supervision session and the child clients completed the YCSRS (Duncan et al., 2006) once a week acting as secondary probes. Baseline stability was determined by the TAQ (Cooley & Klingler, 1989; Fauth et al., 1999) results as the constructs of the TAQ (Cooley & Klingler, 1989; Fauth et al., 1999) are foundational for CT triggers (Gelso, and Hayes, 2007). Once participant one established a stable baseline or trend, then he/she moved into the intervention condition. Once the other participants established a stable baseline, they moved into intermittent measurement of baseline until an intervention effect has occurred for participant one. At that time, participant two then needed to reestablish baseline by three to four data points (Kratochwill et al., 2010), before moving into intervention. This pattern of intermittent measurement and reestablishment of baseline continued for all participants. Prior to the beginning of the study, all participants (counselors) and supervisors completed the demographic forms. Additionally, the supervisors and counselors completed the ICB (Friedman & Gelso, 2000) to ensure that the counselors (participants) were engaging in CT behaviors. At the end of the study, all counselors (participants) completed the post-intervention follow-up questionnaire.
Procedures

Baseline Condition

The baseline condition is used to ensure that the independent variable has been adequately isolated to reduce the probability that external factors were the reason for the potential change in the participant (Kazdin, 2011). However, counseling sessions, especially those in naturalistic settings, can only have so much control. Therefore, during the baseline condition, the counselors did not receive any specific training regarding mindfulness but may be attending continuing education to maintain licensure requirements, if needed. During the baseline condition, the clients meeting criteria for the study engaged in one to three, 45-minute, individual counseling sessions each week with the counselor participant, based on clinical need/availability. The session time only consisted of the time spent with the participant and client and any time outside of direct client contact was not used for measurement or count towards session time. The session was held in a private office within the participants’ agency or mental health office. The counseling room had toys from the three play therapy toy areas, (a) aggressive toys, (b) “real life toys”, (c) creative/art supplies (Landreth, 2012). The participants’ theoretical orientations differed; therefore, the content and structure of the counseling session varied.

Intervention Condition

The intervention condition was identical to the baseline condition except the participants had undergone the intervention. The participants (counselors) continued to engage in therapy as he/she did during baseline but had the intervention training and engaged in the independent practice of the mindfulness skills each week. The intervention consisted of (a) one-time, 3-hour integrated counselor mindfulness training
and (b) daily independent practice. The 3-hour integrated training included two parts: (a) mindfulness practices (mindfulness psychoeducation, guided meditation, and breathing) (Kabat-Zinn, 2013; Thera, 1954) and (b) the theoretical tenets of relating to children and child communication (Landreth, 2012). Upon completion of the training, the participants engaged in a daily practice of the mindfulness skills learned in session as mindfulness only gets stronger with prolonged use (Kabat-Zinn, 2003). The participants documented the practice on a practice log that was provided for them each day. Each week, the researcher collected all the questionnaires, scales, and independent practice logs via SurveyMonkey or email. The researcher plotted the TAQ (Cooley & Klingler, 1989; Fauth et al., 1999) data for analysis each week as immersion in the data provides time and information for change or update to the intervention, if needed (Kazdin, 2011). Although research indicates prolonged and continuous mindfulness practice in order to be effective (Kabat-Zinn, 2003), the 3-hour integrated training was used to simulate professional development training times used in the field for professional counselors and the independent home practices simulated the continued practice needed for effective benefits.

**Data Analysis**

Visual analysis was used analyzing level, data trend, variability, consistency of patterns across similar phases, an immediacy of effect, and data overlap (Kratochwill et al., 2010). Vertical analysis was also be used to ensure there was no change to participants in baseline while other participants received the intervention (Kazdin, 2011).
Ethical Considerations

To ensure that this study was conducted with integrity, strong research fidelity, and employ ethical standards throughout the study; the following measures were taken:

1. This study did not begin until approved by the dissertation chair and committee members as well as the Institutional Review Board at the University of South Carolina.
2. Participation in this study was voluntary with the opportunity to stop participation without retaliation or consequence or loss of incentive and all participants will be provided forms instructing them of these rights.
3. All participants and participant’s clients were deidentified and provided a number/letter combination to ensure confidentiality of participation.
4. All data was stored in a double-locked cabinet and all electronic data will be stored on a password protected computer within a locked room.
5. Consent forms were provided and collected prior to beginning the study.
6. Permission to use measures/instruments was obtained from creators before use.

Significance of the Study

This study is the first experimental investigation completed in a naturalistic setting measuring the effect of an integrated counselor mindfulness training program on reducing negative countertransference. Therefore, the results of this study have implications for professional counselors in the field, counselor training programs, supervisors, and counseling research. The results of this study provide evidence for a new training to assist counselors in managing CT while working with externalized/challenging clients. Additionally, this study introduces the topic of including an integrated training
into counselor education and preparing students/counselors-in-training in managing their CT. The ability to understand oneself in various situations and conditions and the influence one has on another is paramount in the counseling profession. This study added a new skill for counselors to use in and out of session, new topic area to process and use in supervision, and new knowledge for counselor educators to incorporate into counselor education curriculums.

Moreover, although this SCRD study utilized questionnaires instead of overt behaviors, which is supported in the literature (Kazdin, 2011), the addition of a well-designed SCRD study to the counseling literature and profession will hopefully improve the integrity of SCRD in the counseling field. Furthermore, this study also adds to the limited literature on countertransference management strategies and adds to limited experimental designs on this topic. Lastly, the results of this study provide advocacy opportunities for counselors, supervisors, and counselor educators. Counselors have the opportunity to advocate for themselves by exercising the desire to enhance self-care strategies as well as supervisors and counselor educators have the ability to normalize the experience of negative countertransference, teach, and prepare counselors-in-training to manage these experiences to best serve their clients. Additionally, Section C of the *ACA Code of Ethics* (2014) refers to the counselors' professional responsibility emphasizing the importance of the counselor to maintain training and competency to work within the counselors' scope of practice. If counselors are not appropriately working through negative feelings or negative countertransference they may be doing more harm to clients which is a direct violation. Furthermore, this study also illuminates importance and
challenges of working with children or other challenging clients and how the counselor's feelings and level of self-awareness influence client prognosis.

The results of this study also provide many new opportunities for future and further investigation. Based on these results, future research may choose to replicate this study with similar or different populations of clients and counselors-in-training. In addition, other studies may choose to examine the effectiveness of this integrated mindfulness intervention in a more controlled or laboratory setting. Another possible direction is to investigate the use of other surveys/measures of other counseling constructs utilizing SCRD as this may provide further examination of other counseling constructs within a rigid experimental design. Lastly, future studies may choose to incorporate aspects of the integrated training used in this study as a focus for supervision to examine the effects of this training on counselors in a more consistent and long-term setting.

**Chapter Summary**

Chapter One introduced the constructs (countertransference and mindfulness) investigated in this study. The research design was clarified including possible implications of the results as well as limitations to the study and ethical considerations. Chapter two discusses the philosophical and theoretical tenets of negative countertransference and mindfulness as well as a literature review examining both quantitative and qualitative research done in these areas. Chapter Three addresses the methodological procedures that were used in this study to examine the effectiveness of an integrated counselor mindfulness training on reducing negative countertransference for counselors working with children exhibiting externalized behaviors. Chapter Four
presents the results of the study. Chapter Five discusses the implications and potential future investigations based on the results.
CHAPTER TWO: LITERATURE REVIEW

Chapter Two presents the philosophy and theoretical framework that support the key constructs in this investigation; negative countertransference and mindfulness. To best understand negative countertransference, a clear understanding of the importance of the counseling relationship is paramount, as well as recognition of the lineage of countertransference conceptions. A thorough review of the literature is presented examining both qualitative and quantitative investigations of negative countertransference, countertransference management, and mindfulness as it relates to countertransference. The literature search for identifying articles for further examination of negative countertransference involved three strategies. First, utilizing EBSCO Host to search academic databases related to counseling, psychology, and social sciences (Social Sciences Full Text, ERIC, PsycARTICLES, Psychology and Behavioral Sciences Collection, PsycINFO, and PsycTESTS), I searched the term countertransference for the years 1910-2018, which yielded a result of 12,320 articles. I decided to continue to reduce my time frame and only use scholarly peer-revised journals. After reducing the countertransference search to the years 2000-2018, I came across three meta-analyses of all empirical studies and conceptualizations of countertransference over time. I decided to utilize the reference section of these articles to identify the needed sources to best describe the lineage of countertransference theory and conceptualization. The second strategy included using the same search engine and databases to search Negative
Countertransference and the various methodologies (qualitative and quantitative) between the years of 1965-2018, which yielded a result of 7 qualitative studies (5 useable/obtainable) and 12 quantitative studies (6 useable/obtainable). The third strategy used for identifying literature was utilizing another meta-analysis of studies investigating management strategies for countertransference. The guiding research question for this investigation is; Does an integrated counselor mindfulness training have an effect on counselor’s ability to manage negative countertransference while working with children exhibiting externalized behaviors?

**Philosophical Tenets**

**Person-Centered Theory**

Person-centered theory refers to the nature of human interaction and the philosophy of relating to individuals in “growth-producing ways” (Bohart & Watson, 2011, pg. 223). Similarly, child-centered play therapy (CCPT) is essentially utilizing the foundational underpinnings of person-centered theory and applying it to work with children (Landreth, 2011). The foundational belief in person-centered theory and child-centered play therapy is that individuals have the capacity towards continual positive growth. However, in order for the continual growth process to occur most effectively, the individual must be able to remain in the present moment. Additionally, person-centered therapy and CPPT operate under the belief that the individual has the ability to create their own self-growth if provided the opportunity and safe space needed. Counselors foster the clients’ capacity for change or change mechanism through their relationship with their clients modeling being in the present moment, acceptance, and congruence. The key elements or “ways of being” for the counselor to empower the facilitative
relationship for client change and progress are: (a) unconditional positive regard, (b) empathic understanding, (c) the client feels or senses the counselor’s empathy and unconditional positive regard, and (d) acceptance (Rogers, 1957). Essentially reinforcing the relationship between the client and counselor as the vehicle for change. Therefore, any fractures or damage to the therapeutic relationship hinders or negatively influences client progress.

Countertransference experiences are often only valued in person-centered theory as they relate to the therapeutic relationship due to causing discrepancies between the counselors' perception of the client and who the client actually is (Bohart & Watson, 2011). According to person-centered theory, if counselors are feeling triggered by their clients, they are expected to respond to their countertransference feelings or thoughts with empathy, acceptance, and use them for enhanced understanding of those feelings and their clients (Bohart & Watson, 2011). However, counselors must first be aware of their thoughts and feelings towards their clients and its influence on their perception of the client before they can respond to their countertransference experiences. Therefore, the therapeutic relationship and all things that influence the relationship (counselor presence, feelings, and awareness) are essential in counseling effectiveness and client progress.

**Therapeutic relationship.** The therapeutic relationship has been noted as the key change agent and vital common factor as it has been found responsible for 30% of positive client change in therapy (Bordin, 1979; Norcross, 2011; Rogers, 1957). Parth, Datz, Seidman, and Löffler-Stastka (2017) identified a shift in the counseling profession from strict adherence to techniques and interventions to a focus on a more holistic, authentic relationship between client and counselor as the core of therapy. With this shift
of focus, this means there is more of an emphasis on the mutual influence of client and counselor on the success of therapy (Parth, et al., 2017). Historically, the therapeutic relationship or therapeutic alliance has focused on therapeutic goal agreement, bond, tears, repairs of the relationship (Bordin, 1979), and the counselor’s characteristics (Rogers, 1957).

Carl Rogers (1957) identified six core conditions for effective and successful therapy with four factors directly involving how the counselor needs to relate to the client. According to Rogers, the counselor needs to be genuine, integrated, congruent, and exhibit a warm acceptance of the client (Landreth, 2012; Rogers, 1957). In addition to Roger's (1957) core conditions, Greenson (1965) created a three-part model outlining the important factors of the therapeutic alliance; (a) the working alliance- includes goal agreement between client and counselor and formation of a bond; (b) The transference- the client's unconscious reactions/feelings towards the counselor is no longer viewed as a byproduct of psychoanalysis but involved in all therapeutic orientations; (c) The "real" relationship- two, equal people, engaged in a real relationship with one another. This three-part model expands Roger's (1957) core conditions to also account for the client's reactions to the counselor through the idea of transference; however, Greenson's (1965) model does not include the reciprocal influence of the client on the counselor. As Parth and colleagues (2017) noted that the shift from techniques to the therapeutic relationship, this includes growth in recognizing the mutual influence of the client on the counselor and vice versa. Thus, the concept of countertransference has made its way to the forefront as another key factor in the therapeutic relationship. However, the challenge of
understanding countertransference and creating an agreed upon definition among scholars and counselors have taken decades.

**Theory of Countertransference**

The idea of transference has been widely discussed since Freud (1910) coined the term. However, originally the term transference was a concept that counselors and scholars only associated with psychoanalysis as its definition included ideas about the id, ego, and superego that were not widely accepted or understood by other theoretical orientations (Parth et al., 2017). It wasn't until the 1950s that transference and countertransference were beginning to be accepted as parts of other theoretical orientations (Little, 1951). Although transference has been extensively examined by psychoanalysts for decades (Parth et al., 2017), countertransference was considered taboo and went unstudied until the early 1950s (Fiedler, 1951; Hayes, Gelso, & Hummel, 2011). Additionally, the definitions and understanding of transference and countertransference were significantly fragmented and difficult to synthesize as counselors used these terms in different ways and interchangeably when they actually hold very different implications (Gelso, Fassinger, Gomez, & Latts, 1995; Hayes, Gelso, & Hummel, 2011). Therefore, through a meta-analysis of the conceptual literature on countertransference since Freud (1910), Gelso & Hayes (2007) recognized an emergence of four distinct conceptions of countertransference in which they identified limitations to each conception and created an integrated understanding of countertransference that is widely used. From the four distinct conceptions, a combined definition of countertransference was created describing countertransference as the process in which the counselors' inevitable, unresolved conflict leads to misdirected feelings towards the
client that may have been triggered by the counseling content, client's personality, or even the client's appearance, that can either help or hinder the therapeutic relationship and client outcomes depending on the counselor's awareness (Gelso & Hayes, 2007). In addition to the four historical conceptions of countertransference; Hayes (1995) created a structural model of countertransference that has guided research and investigations on CT in counseling.

**Classical conception.** The first conception of countertransference named by Gelso & Hayes (2007) was based on Freud's (1910) definition and beliefs of CT. Freud defined CT as the therapist's unconscious, conflict-based reaction to the patient's transference. He believed that there was no benefit of CT and it could not enhance understanding of the client or promote therapeutic gain. Additionally, Freud (1910) believed the CT was problematic and should be managed as a good psychoanalyst should be able to remain objective and keep his/her personal conflicts out of therapy. Freud’s strict, negative view on CT led to the view of CT as taboo; thus, warranting little study and further desire to investigate. The limitations of the classical conception of CT is its overly restrictive and negative nature and it ignores the natural and inevitable reactions of the therapist (Gelso & Hayes, 2007).

**Totalistic conception.** The next conception of CT came 40 years after the first due to the lack of research and investigation on CT. The Totalistic conception of CT defines CT as *all* of the therapist's reactions to the patient (Little, 1951). This conception included all feelings, thoughts, and behaviors of the counselor as countertransference. Little's (1951) conception legitimized CT and made it an object for therapist's self-investigation as this conception holds that CT may be beneficial if therapists took the
time to study their CT reactions to better understand themselves and their clients. The limitations to this conception are that if all therapist reactions are considered CT, then no reactions are actually CT and the term "therapist reactions" is redundant because it holds the same definition as CT. Additionally, there are varying kinds of therapist reactions that need to be distinguished between CT and that is not considered an unconscious, conflict-based, CT reaction (Gelso & Hayes, 2007).

**Complementary conception.** The third conception of CT is the complementary conception (Racker, 1957). The complimentary conception defines CT as the client exhibiting a "pull" on the therapist; in which the therapist recognizes. Instead of acting out in a similar fashion as others in the client's world do; the therapist restrains the feelings/behaviors/impulses and uses them to better understand what this client is doing to stimulate these feelings within the counselor, thus; better understanding the client's way of relating to others. The counselor then uses this enhanced understanding to identify a particular intervention in therapy to assist the client (Racker, 1957). This conception is similar to the totalistic conception in the belief that CT can be useful and beneficial to the therapeutic process. The limitations to this conception are that this conception only looks at the "pulls" by the client and does not take into consideration the therapists' personality or style of coping with conflicts (Gelso & Hayes, 2007).

**Relational conception.** The fourth and final conception of CT that Gelso and Hayes (2007) recognized throughout the literature is the relational conception (Mitchell, 1993). This conception simply states that CT is mutually created by both the counselor and client and it is the unresolved issues of both that lead to CT manifestations. The
limitations of this conception of CT are the same as the complementary conception in that it did not consider enough of the personality and coping style of the counselor.

From these four historical conceptions of CT, Gelso and Hayes (2007) created an integrated definition and understanding of CT that encompasses aspects from each conception. The source of CT is understood as the therapist’s unresolved conflicts but the authors believe that CT can be useful if the therapist understands their feelings and uses them to better understand the client. Additionally, Gelso and Hayes (2007) believe countertransference is inevitable as counselors are humans and as such we all have “soft spots” and unresolved conflicts. Lastly, they believe that CT incorporates the therapists’ reactions to all clinical content discussed by the client in session, the client’s personality, and the client’s appearance (Gelso & Hayes, 2007). This integrated definition has become the basis and foundation for an agreed upon definition and understanding of CT.

**Structural theory of countertransference.** Lastly, Hayes (1995) created a structural theory of CT to better understand and examine the main components of CT. According to this structural model, CT has 5 key components; (a) CT origins- unresolved conflict within the counselor; (b) CT triggers- actual counseling events that elicit counselor’s unresolved issues; (c) CT manifestations- once triggered, the emotional, cognitive, affective, and behavioral reactions of the counselor; (d) CT effects- results of the manifestations on the counseling relationship and client outcomes; (e) CT management- counselors strategies to cope with their CT (Hayes, 1995). Hayes’ (1995) structural theory of countertransference provides a foundation of inquiry and investigation at different levels of the CT process.
The previous section explained the philosophical and theoretical underpinnings of countertransference, therefore; the next section of this chapter seeks to examine the empirical research conducted on countertransference and more specifically negative countertransference. However, due to the breadth of research on countertransference since Freud (1910) coined the term, the focus of this review will be on qualitative and quantitative studies conducted on countertransference management within the helping profession and studies specifically focused on negative countertransference.

**Empirical Research on Countertransference Management**

One of the first studies conducted on countertransference was completed by Richard Cutler (1958). Cutler (1958) conducted a study examining the influence of countertransference on the therapist's perception of the client's behaviors in session as well as the therapist's behavior in the session. The two therapists in this study were interviewed and asked to review a session and report the behaviors experienced by both the therapist and the client immediately after the session ended. The interviews and the counseling sessions were both recorded for comparison as the interviews were also transcribed and coded. The results of this study illustrated the detrimental effects of countertransference on therapy. Cutler (1958) found that therapists were acting from the "ego behavior" or utilized defense mechanisms (submissive, rejecting, critical, and exaggerated behaviors of the client) when the patient material was related to areas of unresolved conflict in the therapist and the therapists' interventions were judged by reviewers/observers to be less effective. Additionally, this study shows a link to the therapist's increased self-insight to less use of ego-oriented behavior. This study provides the beginning of supportive evidence of the impact of CT on therapy. Although this study
utilized only two participants, the results are the start of further examination needed to better understand CT and strategies to manage its effects.

Almost, 40 years later, Hill, Nutt-Williams, Heaton, Thompson, & Rhodes (1996) conducted a qualitative study examining potential factors that influence therapeutic impasses or barriers of client progress for 12 psychotherapists' engaging in long-term psychotherapy that ended in termination of therapy (Hill et al., 1996). The 12 experienced therapists in the study completed a questionnaire on their counseling experiences. Based on their responses, 8 therapists were then interviewed to gain further understanding of their experiences with such an impasse with a particular client. The researchers utilized consensual qualitative research (CQR) for data analysis creating domains, core ideas, and categories utilizing consensus and auditors for trustworthiness. Hill and colleagues (1996) found through this study that countertransference was one of the most prominent factors to emerge influencing the therapeutic impasse. More specifically, therapist personal issues, frustration, anger, confusion, anxiety, and negative self-efficacy were all factors that influenced the impasse and early termination for 7 of the 11 therapists in this study. Additionally, the therapist's family of origin issues were reported to be stimulated by the client in all 12 therapists as a key factor in the therapeutic barrier and termination. This study helps to build the foundation of the impact countertransference has on therapeutic outcomes and impasses in counseling. However, this study examined the therapist perspective of the origins of the therapeutic impasse but did not inquire about possible strategies in overcoming impasses before they lead to early termination.
Similarly, Baehr (2004) conducted a qualitative study examining strategies used for managing countertransference among 12 experienced therapists. The 12 therapists in this study reported that when they felt more worn and run down, the participants were less self-aware and unable to manage their own feelings before, during, and after session. However, the participants in this study did report that when they engaged in reflection, meditation, and self-care between and after sessions, their self-awareness and insight increased; thus, supporting the belief that the more the therapist is aware of thoughts, feelings, and behaviors, it is more likely the therapist will be able to control/manage them in session. Again, this study acts as a foundational support or springboard future studies to identify helpful strategies for combating countertransference during and in between sessions.

Through research on countertransference, there is evidence supporting the impact and influence of CT on the therapeutic relationship and therapeutic outcomes (Baehr, 2004; Cutler, 1958; Hayes, Gelso & Hummel, 2011; Hill et al., 1996). The next push in CT research was how to manage CT effectively. Peabody and Gelso (1982) conducted a study on the impact or influence of empathy as a mediator for CT feelings and behaviors. This study utilized 20 male counselor trainees engaging in one, one-hour long counseling session with a female client. The Barrett-Lennard Relationship Inventory (BLRI; Barrett-Lennard, 1962) was used to measure the participants' levels of empathy during the relationship building phase of the study. One week later, the participant listened to an audio recording of another client-counselor session in which the clients were either seductive, hostile, or neutral and then the participants chose a pre-determined response to the session. Finally, after the participants responded to the audiotapes, they completed a
CT questionnaire. Utilizing a correlational statistical analysis, the results of this study illustrated that the participants' empathic ability related negatively to CT behavior under conditions the therapist deemed as threatening. Further, the greater the empathic ability of the participant/counselor, the more open the counselors were to their CT feelings; thus, building a strong connection between empathy and CT management of feelings and behaviors (Peabody & Gelso, 1982). A limitation of this study relates to generalizability as it only examined male therapists and female clients; however, the results of the study provide an identification of possible CT management elements.

Gelso, Latts, Gomez, and Fassinger (2002), examined the relationship between therapist CT management abilities and therapy outcome. More specifically, the researchers wanted to assess if the five therapist characteristics associated with CT management were actually helpful in managing CT (self-insight, self-integration, anxiety management, empathy, and conceptualizing skills). This study employed 32 graduate student counselors-in-training (CIT) and their clinical supervisors (21 females, 11 males) and their supervisors. The supervisors listened to audio-recorded sessions of the participants’ sessions with clients in which each participant had between 1-4 clients. All clients in the study were rated as slight to moderate dysfunction. The supervisors rated the counselors’ level of CT with the Countertransference Factor Inventory- Modified (Hayes et al., 1998) and the counselors rated the counseling outcomes using the Counseling Outcome Measure (Gelso & Johnson, 1983). The results of this study indicated that CT management positively correlates with client outcome. The better the CIT is able to manage his/her CT, the more improvement their client’s exhibit at the end of brief therapy. Additionally, self-integration, anxiety management, and conceptualizing
skills were also significantly correlated with client outcome. CIT’s that are able to do the above skills are likely to facilitate client growth. This study employed a particularly small sample size and lacks generalizability due to only using CIT’s. Additionally, therapy outcome was rated by the CIT and supervisees, not a third-party observer or client, which is a limitation as the counselor is not the best at measuring therapeutic behaviors/outcomes. The study I am proposing utilizes multiple measures of the various aspects of CT from multiple perspectives and will utilize a different population that may provide more implications than only using counselors-in-training.

**Empirical Research on Negative Countertransference**

Abbate, Dunafee, & Fenichel (1957) conducted a case example/pilot study, where they described the functioning and experiences of working in a non-residential school for children with schizophrenia. This type of school was novel for the time period, so using detailed anecdotal records kept daily by the teachers themselves, the authors provided some details about how the school was run but also some of the challenges for the teachers working with this population. At the time of this article, the school had 12 children enrolled, 10 boys and 2 girls, all between the ages of 6 and 12. Eleven of the 12 children have been diagnosed with “childhood schizophrenia.” In addition to the diagnosis of “childhood Schizophrenia”, seven of the children were also diagnosed with Autism Spectrum Disorder. The foundational philosophy of this school was focused on the relationship between the teacher and child as the relationship has the greatest impact on changes in the child. The authors described the need for the teachers to be able to empathize and relate with the child, to be sensitive, not feel overwhelmed, and to focus on responding to the child with warmth. Some of the behaviors of the children included
smashing windows with their heads, they would break walls, sweep food and dishes off the tables, kick and bite themselves, and they would often strike out blindly. One of the main and recurrent challenges reported by the teachers was the development of negative countertransference towards the parents and sometimes the children. Although this study was not focused on counselors per se, the philosophy and expectations of the teachers in this school align very closely with person-centered therapy (Rogers, 1957) and have implications for the stress of working with challenging child populations. Additionally, the emergence of negative countertransference for the teachers in this study indicate the possibility for counselors, with similar expectations in therapy, to feel and exhibit negative countertransference when working with challenging child populations.

Epstein Jr., (2003) utilized a case example to illustrate issues of countertransference in therapy working with an emotionally disturbed girl in residential treatment. The author argued that the therapist's unrecognized/irrational beliefs of needing to rescue the child client may, in fact, act as a factor of the strong negative feelings evoked in session. Epstein Jr. (2003) described the client in this case study as an 8-year-old girl who endured years of abandonment, caregiver rejection, neglect, physical, and suspected sexual abuse. This young girl began to exhibit sexualized behaviors toward her siblings and other children as well as engaged in other externalized behaviors such as stealing, threatening others, and aggressive behaviors like refusing to leave the session, throwing toys in session, throwing pillows, swearing, and hitting the counselor. Although this child proved to be very challenging and had many difficult life events to process and work through, the counselor was able to use his feelings and reactions toward the client to better understand her behaviors as communication of her needs. The author/counselor
mentioned the need for child therapists to be aware of the various systems influencing the child as this can be very overwhelming to the therapist and act as a trigger for countertransference reactions such as resentment and frustration. Additionally, the author suggested that working with children can elicit more intense feelings than working with adults and that while children are in “working-through” phase of treatment, the counselor must be able to tolerate the intense feelings/emotions of the child and the therapist.

Lastly, Epstein Jr. (2003) summarizes that working with challenging children may elicit negative countertransference feelings as the counselor struggles with the feelings of not being able to rescue or save the child and these feelings may be displaced to others involved with the client, including the client. Although, Epstein (2003) utilized a case study which provides little ability to generalize and it is only based on one account, however; this study identifies valuable challenges and experiences working with challenging child populations especially in terms of handling negative countertransference. This study supports the rationale for my study but still does not answer the question of the best way to manage negative countertransference for this population.

Rosenbaum, Bain, Esterhuizen, & Frost (2012) conducted a qualitative study utilizing transcribed sessions of two, female therapists engaging in group counseling with mothers that struggle with mother-infant attachment. The study examined the challenges/struggles the two therapists have managing their negative countertransference feelings and reactions towards mothers who share difficulty attaching to their infant child. The results of this study described the two therapists experiencing intensely negative countertransference when listening to the mothers share disturbing child-care
practices such as reduced empathic attunement, a compromised capacity to think, feelings of outrage, horror, anger, impatience, helplessness, and intense feelings of protection towards the infants. Additionally, the two therapists reported struggling with responding to the mothers in a curious and non-judgmental way. Lastly, the therapists reported that the same feelings of dismissal and anger that the therapists were experiencing towards the mothers, the mothers were, therefore, exhibiting those same feelings/behaviors back to the therapists (Rosenbaum, Bain, Esterhuizen, & Frost, 2012). Due to the qualitative nature of the study and the specific population (mothers struggling with infant attachment), these findings don't necessarily generalize to other populations, however, the findings do illustrate the impact of counselor countertransference on facilitating similar behavior in the clients. Therefore, this study does not answer how to manage negative CT but it does strengthen the evidence of the power of negative countertransference on the therapeutic process and on the clients.

Arnd-Caddigan (2013) conducted a qualitative study examining 12 therapist's experiences engaging in imagined conversations with clients outside of sessions. The research design used was a constructivist grounded theory approach in which the transcripts were analyzed using a constant comparison, line-by-line, open, axial coding to arrive at categories that emerged in the data. The interviewers were interested in the various aspects of the client and therapist that were involved in the imagined conversations as well as if the therapist believed the participant was influenced by the use of imagined conversations. According to the participants in the study, the use of imagined conversations assisted with surfacing unconscious negative countertransference feelings and anxiety that, in turn, improved the counselor's ability to process difficult client
material in session. The participants also reported that the surfacing of feelings increased their awareness of these feelings; thus, helping them to manage the feelings before they led to countertransference behaviors and harming the client. There were some design limitations in that the interobserver agreement used to determine the accuracy of interpretation during coding was only accounted for on 10% of the transcripts in which typical interobserver agreement should be done on at least 20% of cases (Kazdin, 2011). This study provides an option for managing negative countertransference feelings and behaviors; however, due to the qualitative nature it cannot be generalized or tested and causation cannot be concluded.

Linn-Walton & Pardasani’s (2014) qualitative study examined the experience of five participants from different helping profession disciplines (two psychologists; two clinical social workers; and an emergency room physician- not a specialist in mental health) working with patients/clients whom they disliked. All participants had at least five years of postgraduate field experience working in the New York City area. The researchers interviewed all the participants utilizing semi-structured interview protocols. The study yielded vital information regarding factors that influence the participants level of dislike or negative feelings towards the patient, as well as the "coping skills" or management strategies for these feelings/behaviors. The two main themes that emerged from the data included; (a) Factors affecting clinician dislike, which included the therapist feeling threatened by the client questioning them, the client having too much control of the session, and the therapist feels threatened physically or emotionally; and (b) Coping Skills, including passing the buck or blaming the client for these feelings, labeling clients negatively, reduced or stopped empathic responses to clients, instilling
fear in client for control, and motivating the client to change “dislikable” traits/behaviors. This study included a broad range of participants but no counselors were used in this study. Although this study identifies similar characteristics and behaviors exhibited by children with externalized behaviors, yet again, it does not provide strategies for counselors to work through these feelings or counter-therapeutic behaviors.

Ligiero and Gelso (2002) conducted a study utilizing 51 doctoral students and their clinical supervisors examining the relationship between CT and the therapeutic and supervisory alliance. Utilizing statistical correlation analysis, Pearson r, the researchers found that CT inversely related to the strength of the working alliance. More specifically, negative CT behaviors were inversely related to both supervision and the therapeutic relationship as positive CT also negatively correlated with the supervisor's rate of the bond/alliance in supervision. Although this study provides support for the influence of CT on the therapeutic and supervisory relationships, it does not provide an answer or solution to managing CT for challenging populations.

Fauth and Hayes (2006) investigated the applicability of the transactional theory of stress to the understanding of countertransference triggers in 68 counselors-in-training working with male clients. The therapeutic engagement was simulated by the CIT’s watching video vignettes of a male client in session in which the CIT was then given time to respond with a therapeutic intervention he/she felt was most appropriate. The participants were assigned to watch either the traditional or non-traditional male client condition to respond to. Upon completing the interaction with the video vignette, the CIT’s then completed the Therapist Appraisal Questionnaire (TAQ, Cooley & Klingler, 1989; Fauth et al., 1999) to assess counselors’ primary appraisals of stress as well as the
Counseling Self-Estimate Inventory (COSE; Larson et al., 1992). The results of the study illustrated that the counselors' stress appraisals predicted their countertransference behavior. Specifically, therapists' negative appraisals were linked with increased distance/avoidance and hesitance with the client. Additionally, counselors who felt more capable of managing their feelings towards the client tended to avoid the client less. In contrast, as the counselors felt more threatened by the client and less able to manage their reactions, hesitance and avoidance increased. Therefore, enhancing counselor confidence in successfully managing their emotional reactions during the session may also be helpful in reducing their negative transference behaviors (Fauth & Hayes, 2006). Although this study yielded powerful results on the influence of stress on negative countertransference, this study only focused on white male. However, the emphasis on stress as a trigger for negative CT is important to working with challenging children population as this population correlates with high-stress levels, thus potentially influencing negative CT.

Rossberg, Karterud, Pedersen, & Friis (2007) conducted a study that examined the extent patients with personality disorders evoked countertransference reactions among therapists as well as the impact of countertransference reactions on the therapeutic relationship and outcomes. This study was conducted in Norway, for 16 months with 11 therapists (2 men and 9 women) working in a psychiatric hospital. The participants in the study were asked to complete the Feeling Word Checklist-58 (FWC-58), two weeks after patients were admitted and two weeks prior to discharge. The therapists completed this survey on 71 patients diagnosed with personality disorders based on the DSM-IV criteria. Additionally, the therapists interacted with these patients routinely as they all led groups with the patients during day treatment. Rossberg, Karterud, Pedersen, & Friis (2007)
found through their study that patients with cluster A and B personality disorders evoked more negative countertransference reactions than those patients diagnosed with cluster C personality disorders. Additionally, those patients that dropped out of treatment elicited significantly more negative countertransference reactions after the first two weeks of treatment than the patients who completed treatment. Lastly, there was a strong negative relationship between the therapist’s negative countertransference reactions and client improvement as there is a possibility that the therapists’ unconscious negative countertransference reactions may have influenced the clients’ early termination of treatment. This study provides yet another connection to the influence of negative countertransference on working with another challenging population; however, does not provide management strategies.

Similar to Rossberg, Karterud, Pedersen, & Friss’s (2007) study, Liebman & Burnette (2013) conducted a study examining the extent in which clients diagnosed with Borderline Personality Disorder (BPD) evoked or triggered negative countertransference reactions within the counselors. This study included 560 clinicians (mostly Caucasian, females, average age of 50). The participants in this study read various vignettes, asked to diagnose the client and then were asked questions about specific areas of countertransference; (a) the extent to which the condition represented a behavioral problem versus a mental illness; (b) levels of distrust; (c) interpersonal efficacy- can the client make friends; (d) empathy; (e) chronicity- do you believe the client's condition can improve; and (f) dangerousness. The results of this study yielded that the participants were more likely to view adolescent clients with BPD as less ill, less trustworthy, and more dangerous than adults with BPD. The researchers also found that that the BPD label
or diagnosis was associated with negative countertransference reactions from the participants as the clinicians who accurately diagnosed the client as BPD exhibited lower levels of empathy toward the client and also viewed the client as more ill. Additionally, this study showed evidence that the more experienced therapists exhibited more positive countertransference than the younger or less experienced counselors working with this population.

Some implications for this study suggest that early clinical exposure and training throughout one's career can be beneficial for managing negative countertransference feelings with more challenging or stigmatized populations. Although this study found strong correlations and clinical implications regarding negative countertransference among clinicians working with clients diagnosed with BPD, the researchers did not use a scale for measuring CT that has been validated among the literature as valid or reliable. This study is another example like the others; that negative countertransference is elicited by particularly challenging populations.

Most recently, Tanzilli, Muzi, Ronningstam, & Lingiardi (2017) conducted another similar study examining the extent in which clients diagnosed with Narcissistic Personality Disorder (NPD) evoked countertransference reactions among 67 psychiatrists and clinical psychologists in Italy working with clients diagnosed with NPD (38 women and 29 men; 41 clinical psychologists and 26 psychiatrists; with a mean average of 9.1 years of experience working in the field). The participants filled out the Therapist Response Questionnaire (TRQ; Betan et al., 2005) based on their experience working with clients diagnosed with NPB. The researchers reported that clients with NPB evoked more hostile/angrier, criticized/devaluated, disengaged, and helpless/inadequate
countertransference patterns among the professionals working with them. Additionally, the participants reported also feeling a lack of close connection with the client, diminished trust, minimal interest, and severe difficulty tuning in emotionally to the patient. Additionally, the participants also reported feeling incompetent, invisible, and anxious. Similar to the other studies on negative countertransference, this study presents more evidence of the significant influence clients have on the therapists, which in turn influences treatment.

Lastly, Guest and Colleagues (In review) conducted a qualitative study similar to Linn-Walton and Pardasani’s (2014) study on helping professionals’ feelings of dislike towards their clients; however, Guest and Colleagues focused on beginning counselors (1-5 years of experience) experiences working with children exhibiting externalized behaviors. This study found similar findings to Linn-Walton and Pardasani (2014) as all 9 participants reported having negative countertransference feelings towards their child clients and engaged in some kind of countertransference behaviors in attempts to cope or manage these feelings. Some of the “coping skills” identified by the participants in this study were: (a) counselor valued being in control, (b) viewed client as a “bully”, (c) shortened session times, (d) left child in session alone, (e) believed client needed to get “his butt beat”, and (f) used deep breathing to calm heart rate and other somatic symptoms. While there were some positive coping skills used (deep breathing); the majority of the counselors’ behaviors did not provide any therapeutic gain to the client. Additionally, all participants reported wanting more training or help on managing these feelings and working with this client population. This study provides more support for the negative influence of negative countertransference feelings on client treatment and
highlights a need for more training on appropriate management of countertransference feelings and behaviors. The previous section examined the empirical research conducted on countertransference and more specifically negative countertransference. The following section provides the theoretical tenets of mindfulness and the change mechanisms of mindfulness before reviewing the empirical literature on mindfulness. However, similar to countertransference, due to the breadth of research on mindfulness, the focus of this review will be on qualitative and quantitative studies conducted on mindfulness practices and countertransference management within the helping profession.

**Mindfulness**

Mindfulness, similar to countertransference, has multiple definitions and has been used in a wide range of ways over time. However, the creation and essence of mindfulness started with Eastern Philosophy, more superficially, Buddhist Doctrine. Thera (1954) does a nice job of putting to rest the variety of definitions on mindfulness and discusses its meaning, origins, and essence behind the practice and belief. According to Thera (1954), mindfulness in its simplest form means, awareness and attention. Mindfulness is seen as the heart of Buddhist beliefs as it provides the answer and cure for human suffering. According to Buddhist doctrine, mindfulness (taming of the mind) heals humanity from the great disease; suffering, that includes greed, hate, and delusion (Thera, 1954). According to Buddhist doctrine, wanting to rid ourselves of suffering is human nature, therefore, mindfulness is for all of humanity. All humans are able to access, utilize, and benefit from mindfulness. Thera (1954) recognizes the hesitation in western culture accepting the Eastern traditions; however, since suffering happens to all
humanity, and no one wants to suffer, then mindfulness is the key to ending suffering, acting as a bridge to connecting east to west.

Thera (1954) also discusses the Buddhist doctrine of the mind. This doctrine says that mindfulness is the bare attention and clear comprehension of 4 objects; (a) feelings/emotions, the feelings we attribute to something; (b) the body, includes body parts, postures, and breathing; (c) the state of the mind; level of awareness or consciousness; (d) the content of the mind, the thoughts. Through focus on these areas, mindfulness provides a freeing of the mind and a healthy level of detachment. Additionally, Thera (1954) states that Buddhist beliefs on mindfulness include 3 main goals that lead to the end of suffering; (a) to know the mind, (b) to shape the mind, (c) to free the mind.

In the past few decades, the concept and practice of mindfulness have found its way to the west. Jon Kabat-Zinn, a primary researcher in this area, has defined mindfulness in a more "western" way without losing the essence of Buddhist philosophy but without citing the Buddhist doctrines. Kabat-Zinn (2003) defines mindfulness as the awareness that is brought on by paying attention on purpose, in the moment, and non-judgmentally. He defines mindfulness as an introspective study of the nature of the mind, emotions, suffering, and the potential release of that suffering. Kabat-Zinn (2003) states that mindfulness is not a performance but a practice that continues to grow and get stronger with more practice. Additionally, Kabat-Zinn (2003) states that the beliefs of mindfulness are always nested in a larger concept of non-harm. In essence, the unexamined thoughts, feelings, and behaviors can and will cause harm to oneself and
others; therefore, mindfulness is used to examine and free those harmful thoughts, feelings, and behaviors.

**Change Mechanisms of Mindfulness**

In addition to creating an understandable, useable, and more western definition of mindfulness; researchers have also sought out ways to create structure or models of mindfulness practice. Kabat-Zinn (2013) states that there are many ways or options to practice mindfulness; however, he believes the practices should include eight foundations of mindfulness practice as these foundations are considered to be the key mechanisms of change; (a) acceptance, (b) trust, (c) patience, (d) open-mindedness, (e) letting go, (f) intention, (g) non-judgement and (h) non-striving. By engaging in these eight foundational elements of mindfulness through various practices, individuals would experience increase awareness, self-insight, and self-regulation (Kabat-Zinn, 2013).

Similarly, Shapiro Carlson, Astin, and Freedman (2006) also created a model of mindfulness based on the Kabat-Zinn (2003)'s definition above. However, this model is a model illustrating "how mindfulness works."

Shapiro and colleagues' (2006) model is called the *Intention, Attention, and Attitude* (IAA) model. This model includes three main steps. The first concept is “Intention”. This is very similar to Thera’s (1954) understanding of mindfulness used to “know, shape, and to free the mind.” For Shapiro et al., (2006), Intention refers to the individual’s intention to move towards, self-regulation, self-exploration, and self-liberation. The next step of the model is “Attention”, meaning the ability to attend for various periods of time, ability to shift the attention to different foci as they come, and the ability to remain focused or attentive and not to try move towards analysis of thoughts or
feelings. The last step is “Attitude”. This step focuses on “how we attend” during mindfulness, pulling from Thera’s (1954) statement that mindfulness is the heart of Buddhist philosophy, meaning we must attend with open awareness, compassion, and empathy; without judgment and condemnation. The goal of Shapiro et al., (2006)’s IAA model is to grow towards re-perceiving which allows the individual to see other perspectives, reevaluate values, and remain open to differences. Through intention, attention, and attitude, mindfulness practices provide the ability to understand the processes of our mind, change our thought processes, and attachment to feelings; thus, freeing the mind to remain present and accept things for how they are (Kabat-Zinn, 2013; Shapiro et al., 2006; Thera, 1954).

Empirical Research on Mindfulness and Countertransference

Mindfulness practices have shown highly significant benefits in the counseling field through various studies. Mindfulness has been shown to reduce anxiety, stress, and depression as well as other physical ailments (Baer, 2003; Kabat-Zinn, 2013). In addition, mindfulness-based practices that focused on improving self-exploration, self-integration, self-regulation, and self-liberation have been extremely successful (Shapiro, 1992). More specifically, the constructs of CT and Mindfulness have been studied in which researchers have found a strong connection between mindfulness trainings focused on enhancing awareness, acceptance, and self-insight in combination with an emphasis on theoretical frameworks, increased conceptualization skills of the participant and reduced CT manifestations (Hayes, Gelso, Hummel, 2011; Latts & Gelso, 1995; Robbins & Jolkovski, 1987). This section will review relevant literature addressing counselor mindfulness and negative countertransference.
Mindfulness and Countertransference

Due to the lack of literature and focus on the negative aspect of countertransference, there are not any studies specifically investigating mindfulness and negative countertransference. However, there are studies investigating countertransference in general and mindfulness; although this is also limited in the literature. Therefore, the following studies focus on the role of mindfulness practices in mediating or managing countertransference.

Countertransference responses including hate, envy, fear or boredom or other emotions due to the interaction with their clients (Najavits, 2000) are experienced by all counselors at some point (Hayes et al., 1998) in which the effects of these feelings have the potential to cause a rupture in the therapeutic relationship. Therefore, Millon and Halewood (2015) conducted a qualitative study interviewing five psychotherapists who regularly practice mindfulness meditation exploring their countertransference experiences. The findings of this study suggest that counselors who practiced mindfulness meditation were more receptive to countertransferential responses using an observing stance, viewed the countertransferential responses through an attitude of compassionate curiosity which allowed them to remain present, in the moment, and resulted in experiencing a deeper therapeutic relationship with the client. This study provides implications on the potential mediating role of mindfulness meditation in acknowledging and using countertransference experiences to facilitate a stronger relationship; however, these findings need to be further investigated quantitatively to strengthen this argument.
The impact counselors have on their clients and client progress is noted in the literature through the importance of the therapeutic relationship (Norcross, 2011) and includes mechanisms like countertransference and mediating factors such as mindfulness. However, there is little research done on how mediating counselor countertransference through mindfulness interventions influence both the counselor and client progress. Grepmaier, Mitterlehner, Rother, & Nickel (2007) conducted a study investigating the treatment results and therapeutic course of 66 inpatient clients who received counseling from five therapists that either practiced Zen meditation or did not practice Zen meditation (experimental group and control group) over a 9-week time-frame. Grepmaier and colleagues (2006) found that the clients working with the therapists who engaged in the Zen meditation reported lower phobic anxiety, anger/hostility, obsessiveness, somatization, and psychoticism symptoms compared to the control group. The results of this study provide a rationale for the importance of the therapist as an instrument and the impact the counselors’ wellbeing has on client outcomes. However, this study does not provide specifics of the intervention of demographic information of their clients and participants.

The ability for counselors to engage in empathy, self-insight, self-integration, anxiety management, and strong conceptualizing ability distinguishes the good from the excellent counselors demonstrating better treatment outcomes (Van Wagoner, Gelso, Hayes, & Diemer, 1991). Mindfulness meditation has been shown to assist counselors in enhancing self-insight and engaging in self-integration. Fatter & Hayes (2013) conducted a correlational study of 100 therapist trainees and 78 supervisors, including both men and women, from a wide range of ethnicities, religions, sexual orientations, and work
settings. Each counselor and supervisor completed The Five Facet Mindfulness Questionnaire (FFMQ; Baer et al., 2006), The Differentiation of Self Inventory-Revised (DSI-R) (Skowron & Friedlander, 1998; Skowron & Schmitt, 2003), and The Countertransference Factors Inventory-Revised (CFI-R; Van Wagoner et al., 1991) to examine if meditation experience, mindfulness, and self-differentiation correlated to stronger countertransference management abilities. The authors found that counselor meditation experience positively correlated with countertransference management abilities as well as the combination of meditation, mindfulness, and self-differentiation positively correlated to CT management abilities. However, there were no significant findings on the impact of mindfulness and self-differentiation alone on CT management abilities. The results of this study indicate the importance of behavioral techniques such as meditation on CT management development.

Mindfulness, Theory, and Countertransference

Although there is growing literary support for utilizing mindfulness practices to manage countertransference (Fatter & Hayes, 2013; Grepmair, Mitterlehner, Rother, & Nickel 2007; Hayes, Gelso, & Hummel, 2011; Millon & Halewood, 2015) there is also research indicating that mindfulness practices alone may not be the best strategy to manage countertransference fully (Latts & Gelso 1995; Robbins & Jolkovski, 1987). This section briefly reviews the two key studies in which the researchers indicate a need for a theoretical complement to mindfulness practices to best combat and manage countertransference.

A fundamental reason mindfulness is helpful in managing countertransference is that mindfulness practices increase awareness. Robbins & Jolkovski (1987) and Latts &
Gelso (1995) conducted studies supporting the notion that counselors with a high awareness of countertransference feelings were less likely to engage in avoidant behaviors or other negative countertransference behaviors. However, both studies also acknowledged that a heightened understanding of the participants' theoretical orientations paired with a heightened awareness of countertransference feelings resulted in the least avoidant behaviors and most promising means to manage countertransference. Robbins and Jolkovski’s (1987) study examined 58 doctoral students and assessed their awareness of countertransference feelings as well as their knowledge and comfort with the participants’ theoretical orientations before listening to two audiotapes of client actresses portraying an insight-oriented psychotherapy session. Upon completion of listening to the audiotapes, the participants completed an index measuring withdrawal behaviors. The researchers used a repeated measures analysis of variance which identified an interaction effect between awareness of countertransference feelings and theoretical framework (Robbins and Jolkovski, 1987).

Similarly, Latts & Gelso, (1995) conducted a study examining graduate trainees’ countertransference behavior towards a female client identifying as a rape victim. The 47-graduate trainee (14 males and 33 females; with varied ethnicities) participants in the study completed a Countertransference Survey (Peabody & Gelso, 1982) measuring the participants’ level of awareness of countertransference feelings as well as a brief survey created by the researchers measuring how well the participants knew and could explain their theoretical orientations. One week later, the 47 graduate participants were asked to respond at six different times during one of two videos of a client-actress portraying a survivor of date rape. The participants’ countertransference behaviors were measured by
analyzing their responses in terms of avoidance or approach. Utilizing hierarchical regression, there was an interaction effect between awareness of feelings and theoretical framework in which the participants with high awareness of countertransference feelings and high understanding of their theoretical framework regarding client conceptualization yielded the least avoidant behaviors; while the participants with low awareness of countertransference feelings and high understanding of their theoretical framework yielded the greatest avoidance. The results of this study provide support for a two-factor model of countertransference management (Latts & Gelso, 1995) suggesting a practice or strategy combining mindfulness practices to increase awareness and enhancement of theoretical understanding and case conceptualization; however, a study utilizing a rigorous experimental design could further substantiate these findings.

**Conclusion**

Chapter two discussed the philosophical and theoretical tenets of negative countertransference and mindfulness and provided a literature review examining both quantitative and qualitative research done in both areas. There appears to be strong literary support for the impact and influence of countertransference, more specifically negative countertransference, on the therapeutic relationship and client outcomes. Most studies conducted on countertransference included psychologists, psychiatrists, and therapists that are engaged in psychoanalysis, with very few studies examining this construct among counselors ascribing to other theoretical approaches. Additionally, although there are some studies looking at strategies for managing countertransference, there are even fewer looking at how to manage negative CT and even less CT management research with various populations. Moreover, the methodological
approaches to researching and identifying possible management strategies for CT, more specifically negative CT, appear to be qualitative or correlational in nature. The experimental studies that have been completed on management strategies for CT are few and have been focused in a more laboratory or controlled setting utilizing graduate students and not experienced counselors (Hayes, Gelso, & Hummel, 2011). Therefore, there is a huge gap in the literature from a methodological standpoint in that there is a great need for more experimental research conducted in naturalistic settings with experienced counselors and not just graduate students.

Additionally, there are very few CT research studies done focusing on children and no single case research design studies completed on countertransference or negative countertransference. Consequently, my guiding research question for this study; How is negative countertransference effected by an integrated counselor awareness training among counselors working with children exhibiting externalized behaviors?, has not been adequately answered or even explored in the current literature on CT or negative CT. Chapter three addresses the methodological procedures that were used in this study to examine the effectiveness of an integrated counselor mindfulness training on reducing negative countertransference for counselors working with children exhibiting externalized behaviors. Chapter four presents the results of the study and chapter five discusses the implications and potential future investigations based on the results.

**Theoretical Tenets of Relating to Children**

A combination or integration of mindfulness practices to increase awareness and a heightened theoretical awareness focusing on case conceptualization skills greatly manages countertransference feelings among counselors (Hayes, Gelso, & Hummel,
Therefore, when focusing on child clients, understanding the theory behind child development and child interaction in session is essential for competent clinical practice and managing countertransference feelings. Developmentally, children communicate differently than adults due to their inability to think abstractly and need to interact with the world in concrete ways (Landreth, 2012; Piaget, 1954). Adults typically rely on verbal communication to interact and express emotions. Although children are able to communicate using words and adult verbalizations, words are viewed as made up symbols and abstractions (Piaget, 1962). Additionally, children’s feelings are typically not accessible at a verbal level and words do not adequately express the children’s emotions as children are unable to focus emotionally on the intensity of their emotions during verbalization (Landreth, 2012).

Therefore, children often use behavior to express emotions or feelings of joy, frustration, anger, sadness, and fear as behaviors or actions to manipulate the present moment providing concrete expression of the child (Landreth, 2012).

Although it may be developmentally appropriate for children to express feelings through behaviors and action; children’s emotional expressions can be stressful for those around them due to the lack of understanding and ability to accept the varied developmental level of the child. Children must be approached from a developmental perspective with empathy and acceptance (Glover & Landreth, 2000) and therapists must release their world of reality and need for verbal expression in order to move into more of a conceptual-expressive world of children (Landreth, 2012). Therefore, using an integrated theoretical and mindfulness training that includes elements of mindfulness and the theoretical tenets of relating to children therapeutically and children’s communication
may improve counselor’s ability to accept, manage negative countertransference, enhance the counselor’s conceptualization skills of the child client, and provide appropriate and needed care to challenging child clients.
CHAPTER THREE: METHOD

Chapter's 1 and 2 provided both a general understanding and introduction of the issue or problem under investigation and an in-depth look of the constructs being evaluated in this study. This chapter discusses the plan for inquiry and provides a map or guide outlining the examination of the constructs. The major sections of this chapter include information on the research design, the setting and participants of the study, the treatment, the various instruments and measures used for data collection, data collection and data analysis procedures, and attempts to minimize risk for all involved in the study. The research questions for this study were investigated quantitatively and experimentally as I sought to test the effectiveness of a new intervention on a specific population (Creswell, 2008, Kazdin, 2011).

Research Questions and Hypotheses

The purpose of this research study was to investigate the effect of an integrated counselor mindfulness training on negative countertransference for counselors working with children exhibiting externalized behaviors. The following research questions were investigated in this study.

Primary Research Question

Does an integrated counselor mindfulness training have an effect on counselor’s feelings of negative countertransference while working with children exhibiting externalized behaviors as measured by, Therapist Appraisal Questionnaire (Cooley & Klingler, 1989; Fauth et al., 1999)?
Hypothesis

The integrated counselor mindfulness training will reduce counselors’ feelings of negative countertransference towards child clients exhibiting externalized behaviors in session (Hayes, Gelso, & Hummel, 2011; Latts & Gelso, 1995; Robbins & Jolkovski, 1987).

Secondary Research Question One

Does an integrated counselor mindfulness training influence the counselor’s ability to manage negative countertransference while working with children exhibiting externalized behaviors as measured by the Countertransference Management Scale (Perez-Rojas, et al., 2017)?

Hypothesis

The integrated counselor mindfulness training will increase the counselors’ ability to manage negative countertransference while working with children exhibiting externalized behaviors in session (Hayes, Gelso, & Hummel, 2011; Latts & Gelso, 1995; Robbins & Jolkovski, 1987).

Secondary Research Question Two

Does an integrated counselor mindfulness training influence the client’s perception of the counseling relationship in session, as measured by the Young Child Session Rating Scale (Duncan et al., 2006)?

Hypothesis

The integrated counselor mindfulness training will improve the client’s perception of the therapeutic relationship in session (Hayes, Gelso, & Hummel, 2011).
Research Design

Single case research design (SCRD), more specifically multiple probe design, is the experimental design that was used in this study. Single case research designs are more often used in educational research but have started to make a strong emergence into the counseling field. Due to the rigor of the research design, single case research can demonstrate causality and generalizability just as other between groups experimental designs, as the individual or group that is involved in the study acts as its own control (Kratochwill et al., 2010). Single case research is often used for the following reasons; (a) when testing the effectiveness of an intervention; (b) if the population of interest is small or specialized as it may be difficult to find large numbers of participants meeting that criteria; and (c) if the intervention of interest is new or novel to ensure there are no adverse effects from the intervention before using it with larger groups (Kazdin, 2011).

This study fits well with SCRD as I am investigating the effectiveness of a new intervention on a specialized group of participants. Similar to multiple baseline design, the multiple probe design can be implemented across participants, settings, or interventions. For this study, multiple probe design across participants will be used. In multiple probe design, the participants are measured intermittently as opposed to every single session like multiple baseline designs. This intermittent measurement allows for a reduction of testing as it can be strenuous on participants (Kazdin, 2011). Additionally, the consistent testing for this study may lead to diffusion of treatment as continuous testing may lead to increased counselor awareness of CT, which is a goal for the training; thus, leading the counselor to make changes/process CT before the intervention is given.
Dependent and Independent Variables

Traditionally in SCRD, this section of the methodology includes the operational definitions used for identifying the overt behaviors that will be measured in the study, as well as discussing the recording system used for data collection and the importance of Interobserver Agreement for reliability purposes (Kazdin, 2011). However, since I am using questionnaires and surveys to measure my constructs, I will not discuss those areas in this section. Instead, I will define my constructs based on the definitions in the literature corresponding to the instruments used to measure them and for clarity of terms.

Dependent Variables

The primary dependent variable, measured to illustrate cause and effect of the independent variable, investigated in this study was negative countertransference feelings. In addition to the counselors’ feelings of negative countertransference, countertransference management and the clients’ perception of the therapeutic relationship were also examined acting as secondary dependent variables. The definition of each term follows.

Countertransference (CT). Countertransference is the overarching construct of study. Using Gelso and Hayes’s (2007) definition of countertransference; countertransference is the process in which the counselors' inevitable, unresolved conflict leads to misdirected feelings towards the client that may have been triggered by the counseling content, client's personality, or even the client's appearance, that can either help or hinder the therapeutic relationship and client outcome depending on the counselor's awareness (Gelso & Hayes, 2007). Countertransference can be helpful to therapy if the counselor has the awareness of these feelings and triggers and uses them to
better understand the client (Gelso & Hayes, 2007). For example, if the counselor becomes aware of the frustration and anger he/she feels towards a child client that is throwing toys and not listening to the counselor; then the counselor may be able to use that awareness to better understand that this child is trying to communicate that he or she is angry and view the session as a microcosm of the client’s outer world and interactions with others. More specifically, *negative countertransference*, the specific construct of CT that will be measured is often defined as the under-involvement with the client including negative feelings or reactions the counselor experiences towards the clients (i.e. avoidant behavior, withdrawal, criticism, anxiety, anger, disgust, etc.) (Friedman & Gelso, 2000).

**Countertransference management.** Countertransference management is defined as the therapist behaviors, characteristics, strategies or techniques counselors use to regulate and use their countertransference reactions productively as well as to reduce their countertransference experiences (Hayes et al., 1998). Some examples of positive countertransference management include reflective supervision, increased self-insight, anxiety management, enhanced conceptualization skills, self-integration, and empathy (Hayes, Gelso, Van Wagoner, & Diemer, 1991; Latts & Gelso, 1995).

**Countertransference feelings.** The counselor’s feelings can be described as one of the ways in which countertransference manifests itself within the counselor and includes all feelings from hopeful, eager, excited, happy, exhilarated to threat, harm, sad, angry, disgusted, while in session when working with a child exhibiting externalized behaviors (Fauth et al., 1999).

**Client’s perspective of the session/therapist.** The client’s view of how the counselor did in session (did the client feel heard by the counselor, understood by the
counselor, respected by the counselor, etc.) (Duncan et al., 2006) is important to the strength of the therapeutic relationship as the client’s perception of the counselor is a key element to establishing a strong therapeutic relationship (Rogers, 1957).

Independent Variable

The independent variable for this study is the 3-hour integrated counselor mindfulness training with daily follow-up mindfulness practice. The training includes two parts, (a) guided instruction/training and (b) an independent practice of mindfulness skills. The guided instruction also includes two parts: (a) mindfulness strategies (mindfulness psychoeducation, guided meditation, and breathing) and (b) the theoretical tenets of relating to children. The mindfulness component includes the three components of Shapiro et al.’s (2006) IAA model of how mindfulness works: Intention, Attention, and Attitude and practices supported by Mindfulness-Based Stress Reduction curriculum (MBSR; Kabat-Zinn, 2013). The guided meditations throughout the training are scripted, emphasizing awareness and loving-kindness meditations and are able to be used continuously (Thera, 1954), while the breathing exercises follow instruction from Kabat-Zinn's (2013) diaphragmatic breathing explanations. The theoretical portion of the training emphasizes the teachings of Carl Rogers (1957) and Gary Landreth (2012) of the therapeutic relationship and relating to children developmentally.

Population and Sampling Procedures

Population and Sampling

After reviewing and analyzing the current literature on Countertransference more specifically negative countertransference, there is a lack of naturalistic, experimental studies as the majority of the quantitative studies on CT and mindfulness are correlational
and take place within a laboratory setting. In regards to the demographics gathered in this area; most of the CT literature focuses on particular adult client groups or diagnoses, CT management and triggers, and mental health practitioners but not exclusively counselors or level of experience of the participants. Additionally, most of the studies do not report race/ethnicity, average age, gender, or even a specific number of years of experience for the participants. Therefore, this study followed the trend in the literature and filled the gaps by conducting an experimental investigation with current counselors; not graduate students, in a naturalistic setting, with a specific child-client population. Additionally, the researcher collected demographic information on the clients’ ethnicities, ages, genders, and diagnoses as well as the participants' and supervisors' ethnicity, age, gender, and specific time working in the counseling field.

Upon IRB approval, participants were solicited via purposive, criterion-based sampling methods (Creswell, 2008), targeting existing relationships with mental health agencies within the northern parts of South Carolina and western parts of North Carolina and following strict inclusion criteria parameters. This regional location was selected due to the professional relationships already established by the researcher, in addition to the need for consistent data collection over a long period of time and feasibility of implementing the intervention. Data collection and intervention was held in the participants’ therapeutic agency in which they worked.

The inclusion criteria for this study included participants who were: (a) Mental Health Counselors (LPC or LPC-A); (b) have one to five years of field experience as a counselor; (c) who worked with children, ages three to nine, that exhibited externalized behaviors in session (i.e. hitting, kicking, screaming, throwing/breaking things, etc.); (d)
supervisors and counselors reported the counselor is experiencing at least one negative countertransference behavior (as measured by The Inventory of Countertransference Behavior (ICB; Friedman & Gelso, 2000), and (e) the counselors reported not having prior experience or training in mindfulness practices. Ideally, all participants needed to work at the same location to reduce extraneous variables and to maintain as homogenous a sample as possible as this is extremely important for SCRDs (Kratochwill et al., 2010). All participants (counselors) consented to participate in the study. Multiple probe design requires at least 3 participants to illustrate a basic effect; however, 4 participants are recommended (Kazdin, 2011). Therefore, I recruited 4 participants for this study.

Sampling Procedure

Counselors and supervisors. The researcher contacted mental health agencies, outpatient agencies, inpatient agencies, therapeutic day programs, and therapeutic preschools via email and telephone communication in North and South Carolina who have a high volume of child referrals and clients. The supervisors and counselors of the various mental health locations were contacted offering information regarding the study, inclusion criteria, and scheduling time for the researcher to come meet with the supervisors and counselors interested in participating in the study. After two weeks of recruitment, four Licensed Professional Counselor Associates (LPC-A), working in a therapeutic pre-school with children ages three-nine who exhibit externalized behaviors volunteered to participate. All participants were informed that participation was voluntary and were provided consent forms detailing expectations for participation as well as their rights as participants. Demographic data was collected on the counselors, supervisors, and the identified clients. All counselors participating in this study, work at the same
therapeutic preschool, received supervision for licensure, and have not received any formal mindfulness training; however, they were able to receive continuing education as needed for licensure.

**Clients of counselors.** The clients used in the study were current clients of the participants. Each counselor identified one current client on his/her caseload between the ages of three to five due to the age restrictions of a therapeutic pre-school, currently receiving weekly therapy from the counselor and exhibited externalized behaviors in session per counselor’s report. The clients were unaware that the counselors were involved in a study and did not need to assent or have parental consent as their involvement in the study was nothing outside of typical therapeutic protocols per IRB. The child client was only involved in data collection as the client was asked once a week to evaluate his or her feelings towards his/her counselor.

**Implementer**

Information and professional credentials on the implementer and his or her relationship to the participants are important in SCRD as this speaks to the level of internal consistency and replication factors when implementing the intervention (Kazdin, 2011). I, the primary researcher, will be the interventionist/implementor in this study. I am a doctoral candidate, a Licensed Professional Counselor (NC), a Registered Play Therapist, a Qualified Supervisor, and am well versed in mindfulness through my training in Eastern mindfulness philosophies in India as well as my completion of an 8-week training in Mindfulness-Based Stress Reduction (MBSR; Kabat-Zinn, 2013). Although I utilized snowball, criterion-based sampling methods through pre-established relationships with mental health agencies in the North and South Carolina, I will have no relationship
to the clients and I will not know the counselors/participants before entering into the study.

**Materials**

Materials needed for this study were the surveys/questionnaires used to measure countertransference management, countertransference feelings, and the client’s perspectives on the session and counselor. Additionally, audio recording equipment to record the intervention training sessions were employed for fidelity checks throughout the study as well as independent mindfulness practice logs that the participants completed after the intervention training. Typically, in SCRD, video recording equipment is used for data collection and measuring overt behaviors. However, this study did not include measuring overt behaviors, so the video equipment was not needed.

**Instrumentation**

Typically, single case research designs (SCRD) use direct observation for measurement purposes, however, surveys and questionnaires can be used in SCRD for data collection as well (Kazdin, 2011). Therefore, this study used the following questionnaires/scales to measure my dependent variables. All scales for the study are described below; however, due to utilizing multiple scales in this study, a brief overview of the scales is provided to better illustrate who is completing the various scales throughout the study. The Inventory of Countertransference Behavior (ICB; Friedman & Gelso, 2000) was used during participant recruitment as an inclusion criterion and at the completion of the study. The ICB (Friedman & Gelso, 2000) was completed by both, the counselors and their supervisors, to measure current levels of countertransference behaviors experienced by the participants in the session. The Therapist Appraisal
Questionnaire (TAQ; Cooley & Klingler, 1989; Fauth et al., 1999) was the primary probe used for this study measuring the counselors’ feelings towards the client. This survey was completed intermittently by the counselors in the study after each session with their clients.

The Countertransference Management Scale (CMS; Perez-Rojas et al., 2017) was a secondary probe used to measure the counselors’ ability to manage their countertransference. This survey was completed by the counselors' supervisors to include another perspective as counselors struggle in accurately depicting their levels of countertransference and management abilities (Friedman & Gelso, 2000). Lastly, the Young Child Session Rating Scale (YCSRS; Duncan et al., 2006) was another secondary probe that was completed intermittently by the child client with assistance from the counselor, to gather feedback regarding the child’s feelings towards the counselor during that session.

**Demographic Survey**

The demographic surveys (see Appendices C-D) created by the researcher were provided to the counselors and supervisors participating in the study collecting various demographic information (e.g., gender, age, ethnicity, highest level of education completed, number of years as a counselor/supervisor, number of months working with supervisor/counselor, prior exposure to mindfulness, etc.). This demographic form was completed prior to beginning the study.

**Daily Mindfulness Activity Log**

The *Daily Mindfulness Activity Log* (Appendix E), created by the researcher, is a self-report instrument used to collect and guide the counselor participants through various daily mindfulness exercises used during the intervention phase of the study. The information collected includes time of day the mindfulness exercise was practiced,
duration of exercise, type of mindfulness exercise, and effects (e.g., feelings, thoughts, mood, somatic symptoms, etc.) before, during, and after the mindfulness exercise. Additionally, the mindfulness log also includes an area of reflection for the participants to complete after each mindfulness practice. Lastly, a question asking the participants how likely they were to engage in at least one daily mindfulness practice, rated on a 5-point, Likert-Scale (1-Not at all likely to 5-Very likely), was used as a retention practice (Leon, Demirtas, & Hedeker, 2007; Rabideau et al., 2014) to enhance participant engagement in the independent mindfulness practices. Although this data provided information to the researcher regarding preference and use of particular mindfulness exercises, the Daily Mindfulness Logs are also used to assist the counselor participants with accountability for continued mindfulness practice as continued mindfulness practice is the crux on mindfulness effectiveness (Kabat-Zinn, 2003).

**Post-Intervention Follow-Up Questionnaire**

The Post-Intervention Follow-Up Questionnaire, created by the researcher, is a self-report questionnaire to collect information and thoughts from the participants about the intervention. This questionnaire is a combination of a 3-point, Likert-style questionnaire and open-ended questions inquiring about the effectiveness of the intervention in reducing and managing negative countertransference, ease of self-guided mindfulness practices, and recommendations for improvements on the intervention. The post-intervention follow-up questionnaire assessed the social validity (Kazdin, 2011) of the intervention; a key component to single case research design. The questionnaire was sent to the counselor participants in the study upon completion of data collection via email.
The Inventory of Countertransference Behavior (ICB; Friedman & Gelso, 2000)

The Inventory of Countertransference Behavior (ICB) is a 21-item, self-report instrument created for counselors and counselor-supervisors to evaluate countertransference behaviors and is rated on a 5-point scale (1 = to little or no extent, 5 = to a great extent). The ICB has two subscales that evaluate positive CT (e.g., “over-supported the client”) and negative CT behavior (e.g., “rejected the client”). The positive CT items on the inventory are: items 1, 3, 4, 7, 8, 12, 13, 14, 15, 18 and the negative CT items on the inventory are: item 2, 5, 6, 9, 10, 11, 16, 17, 19, 20, 21. This study only used questions from the negative CT scale. The ICB relates highly to the other measures of CT and CT management, working alliance, and client and therapist attachment and reports a .79 reliability score (Friedman & Gelso, 2000) for both scales. Additionally, the Negative Countertransference Scale reports moderate to high correlation to factors that are considered “inappropriate counselor behaviors (r = .79) and the authors report a significant convergent validity between the ICB and the Countertransference Index (CT) (r = .43) and significance between the ICB and Countertransference Factors Inventory-Revised (CFI-R) (r = -.62) (Friedman & Gelso, 2000). This scale was completed by the counselors and their supervisors as a part of the inclusion criteria prior to beginning the study to ensure that the counselor participants in the study were, in fact, engaging in at least one negative countertransference behavior prior to receiving the intervention as well upon completion of the study as a secondary probe.

Therapist Appraisal Questionnaire (TAQ; Cooley & Klingler, 1989; Fauth et al., 1999)

The Therapist Appraisal Questionnaire is a 16-item, self-report, questionnaire utilizing Likert-type items (0 = not at all, 5 = a great deal) measuring three constructs. The TAQ
indirectly assesses the counselors’ stress appraisals of a situation or client via the emotions associated with three key constructs. The three constructs measured by the TAQ are the counselor’s feelings of challenge (exhilaration and excitement, etc.), threat (worry and anxiety, etc.), and harm (anger, disappointment, disgust, etc.) as they are experienced in session. Fauth et al. (1999) combined the threat and harm scales to create a negative stress scale which highly correlates with counselor’s ability to manage their self-awareness and value conflicts between clients (Larson, et al., 1992). The TAQ was sent to the counselors via text through the SurveyMonkey application on the researcher’s phone as the counselors (participants) were expected to complete the survey after each session with the identified clients.

Upon completion of the surveys after each session, the researcher then input the data into an excel file for graphing and visual data analysis. Scores were calculated by adding up all scores for each construct with higher scores indicating greater levels of that particular feeling. The threat and harm construct scores were combined, with a score range from 0 – 40, to denote negative countertransference feelings; while the challenge construct remained independent with scores ranging from 0 – 30, to denote more positive feelings of towards the client. This instrument was used to identify the potential feelings associated with CT triggers and potential manifestations. The TAQ has strong internal consistency (.74-.90) and construct validity (Cooley & Klingler, 1989; Fauth et al., 1999). The Therapist Appraisal Questionnaire has strong internal consistency (.74-.90) and construct validity (Cooley & Klingler, 1989; Fauth et al., 1999).

**Countertransference Management Scale (CMS; Perez-Rojas et al., 2017)**

The Countertransference Management Scale is a 22-item, self-report, 5-point Likert instrument (ranging from 1 to 5; 1 = Strongly Disagree and 5 = Strongly Agree) measuring the
supervisors’ perceptions of the extent in which the counselors exhibit the two elements of CT management in session with clients; (a) understanding self and client and (b) self-integration and regulation. Supervisors completed this inventory at the end of each supervision meeting scoring the counselor in each of the areas noted above. The supervisors received this scale, entered through SurveyMonkey, via email on the days supervision was scheduled with the counselor. The scores were averaged for each subscale with a higher score indicating the counselor having a stronger ability to manage countertransference through either (a) understanding self and client and (b) self-integration and regulation. The questions items averaged to compute the CMS score for the subscale Understanding Self and Client were survey items 3, 4, 5, 8, 9, 10, 11, 13, 14, 16, 18, 21 and the questions items averaged to compute the CMS score for the subscale Self-Integration and Regulation were survey items 1, 2, 6, 7, 12, 15, 17, 19, 20, 22. A total score of Countertransference Management can also be calculated by averaging scores for all 22 items. The internal consistency for the subscales are .93 and .95. Additionally, it has high high convergent and criterion-related validity between the Countertransference Factors Inventory (CFI, Latts, 1996) and counselors effectiveness as rated by the supervisor. (Perez-Rojas et al., 2017).

**Young Child Session Rating Scale (YCSRS; Duncan et al., 2006)**

This single-question, self-report scale measured the client’s perspective of the counseling relationship using four pictures of faces ranging from happy, unsure, sad, a blank face for the child to draw in their own faces for the child to indicate their perception of their relationship with the counselor. Internal consistency of the Session Rating Scale (SRS) for adults is reported at .88 (Duncan, et al., 2003) which is similar to the Child Session Rating Scale’s reliability and consistency (Duncan, et al., 2006). However, the YCSRS does not have
any psychometric prosperities but is a useful way to engage young children regarding their assessment of the counselor and their experience. With the help of another adult in the agency, the child clients of the counselors/participants completed this scale by pointing at a face one time each week and the scale was scanned and sent to the researcher via email each week. Due to the child clients' ages and developmental levels often completing the YCRS, the reliability and validity of this scale have not been objectively measured; however, the use of this scale was to attempt to gain some feedback from the participant's clients.

**Interobserver Agreement (IOA)**

In traditional SCRD, this section is used to describe the method in which Interobserver Agreement (IOA) will be calculated for the study. However, this study did not use IOA during data collection but did use IOA to enhance the rigor of treatment fidelity procedures. Therefore, instead of having one outside observer utilize a treatment fidelity checklist to determine accurate implementation of the intervention, two outside observers engaged in IOA using the same check-lists to ensure a level of agreement and strong determination of treatment fidelity. This will be further described in the treatment fidelity section.

**Data Collection**

Multiple probe design does not require every participant to engage in continuous measurement every session (Kazdin, 2011). For this study, all counselor participants completed the Therapist Appraisal Questionnaire (TAQ; Cooley & Klingler, 1989; Fauth et al., 1999) after every session with the identified clients until baseline stability was established (typically three to five sessions or as long as needed for the baseline to be stable). The supervisors of the counselor participants completed the Countertransference Management
Scale (CMS; (Perez-Rojas, et al., 2017) after every supervision session and the identified client of each participant completed the Young Child Session Rating Scale (YCSRS; Duncan et al., 2006) intermittently (roughly once per week), acting as secondary probes. Prior to the beginning of the study, all participants (counselors) and supervisors completed the demographic forms. Demographic data on the participants' clients was gathered from the participants. Additionally, the participants and supervisors completed the Inventory for Countertransference Behavior (ICB; Friedman & Gelso, 2000) at the beginning and the end of the study to ensure that the counselors (participants) were engaging in CT behaviors prior to the study and to measure the change in CT behaviors after the study. At the end of the study, all participants (counselors) completed the post-intervention follow-up questionnaire for social validity purposes.

**Procedures**

As mentioned earlier, single case research design (SCRD) is most often used; (a) when testing the effectiveness of an intervention; (b) if the population of interest is small or specialized as it may be difficult to find large numbers of participants meeting that criteria; and (c) if the intervention of interest is new or novel to ensure there are no adverse effects from the intervention before using it with larger groups (Kazdin, 2011). The purpose of this study meets the criteria of a SCRD as this study investigated the effectiveness of a new intervention on a specialized group of participants; an integrated mindfulness training on counselors working with children exhibiting externalized behaviors. Multiple probe design allows for continuous, repeated measurement across participants, a staple of SCRD (Kratochwill et al., 2010) but utilizes intermittent measurement to reduce various threats to validity (testing fatigue, diffusion of treatment,
extended time in baseline). In multiple probe design, not every participant will have to engage in continuous measurement every session. For this study all participants (counselors) completed the TAQ (Cooley & Klingler, 1989; Fauth et al., 1999) every session, the supervisors completed the CMS (Perez-Rojas, et al., 2017) after every supervision session, and the clients completed the YCSRS (Duncan et al., 2006) every third session with assistance from an adult. Baseline stability was determined by the TAQ (Cooley & Klingler, 1989; Fauth et al., 1999) results as the constructs of the TAQ (Cooley & Klingler, 1989; Fauth et al., 1999) are foundational for CT triggers (Gelso & Hayes, 2007). All four participants entered the baseline condition at the same time and engaged in consistent measurement of the TAQ (Cooley & Klingler, 1989; Fauth et al., 1999) after every session with the identified client. Once participant one established a stable baseline or trend based on TAQ (Cooley & Klingler, 1989; Fauth et al., 1999) results, then she moved into the intervention condition. Once the other participants established a stable baseline, they then moved into intermittent measurement of baseline until an intervention effect occurred for participant one. At that time, participant two then needed to reestablish baseline, by 3-4 data points (Kratochwill et al., 2010), before moving into the intervention phase. This pattern of intermittent measurement and reestablishment of baseline continued for all participants throughout the study.

**Baseline Condition**

The baseline condition is used to ensure that the independent variable has been adequately isolated to reduce the probability that external factors were the reason for the potential change in the participant (Ledford & Gast, 2018; Kazdin, 2011). However, counseling sessions, especially those in naturalistic settings, can only have so much control. Therefore, during the baseline condition, the counselors did not receive any
specific training regarding mindfulness but were allowed to attend other continuing education to maintain licensure requirements, if needed. Additionally, the counselors did not have any prior experience with mindfulness practices, per self-report. During the baseline phase, the participants engaged in individual sessions with clients as typically scheduled. Not all clients treated by the participants qualified for the study; however, the participants continued to treat other clients outside of the study that were not measured for the outcomes of this study. Each participant identified one of his/her current clients that met the criteria for participation. The clients meeting criteria for the study were scheduled to receive three, 45-minute, individual counseling sessions each week with the counselor participant, based on the clinical need and requirements of the therapeutic preschool in which the counselors were employed. All sessions in which the client and counselor participant were present for the entire length of the session were used for measurement or counted as one of the three weekly sessions. For example, one session a week was required by the employer to include one parent or guardian in session with the child client. The sessions were held in a private office within the participants' agency or pre-school. The counseling room included areas to sit for the counselor and client as well as toys from the three play therapy toy areas, (a) aggressive toys, (b) "real life toys", (c) creative/art supplies (Landreth, 2012). Additionally, the participants' theoretical orientations may differ; therefore, the content and structure of the counseling session may vary.

**Intervention Condition**

The intervention condition was identical to the baseline condition except the participants engaged in the intervention. The participants continued to engage in therapy
as he/she did during baseline but also engaged in the intervention training and in independent mindfulness practice. The intervention was two-pronged or consisted of two stages: a one-time, 3-hour integrated counselor mindfulness training and continuous daily independent practice. The 3-hour integrated training, created by the researcher, included two parts: (a) a mindfulness training informed by the Kabat-Zinn's Mindfulness-Based Stress Reduction (2013), Shapiro et al.'s (2006) Intention, Attention, Attitude Model of mindfulness, and Thera's (1954) traditional meditation practice and (b) theoretical tenets of relating to children therapeutically (Landreth, 2012). The choices of independent practices consisted of diaphragmatic breathing exercises (Kabat-Zinn, 2013), body scans, a variety of meditations (Kabat-Zinn, 2013; Thera, 1954), and reflections. The integrated mindfulness counselor training was conducted in the participants' agency/office or other private room available, while the independent practices were suggested for daily use at the participants home or office.

The integrated mindfulness training was a one-on-one training between the interventionist and the participant before the participant entered baseline. The integrated mindfulness training followed the following format: (a) introduction and welcome, (b) opening practice (e.g. breathing exercise and brief reflection), (c) Understanding the brain and stress (MBSR curriculum; Kabat-Zinn, 2013), (d) breathing exercise and body scan, (e) follow-up (questions and reflections), (f) guided meditation, (g) follow-up, (h) break, (i) participants discussion of clients exhibiting externalized behaviors, (j) breathing exercise, (k) follow-up, (l) theoretical tenets of relating to children, (m) reframing practice, (n) pairing and breathing exercise, (o) closing guided meditation practice, (p) follow-up (questions and reflections), (q) review of home practice requirements. Upon
completion of the training, the participants were expected to engage in continual practice of the mindfulness skills learned in session as mindfulness only gets stronger with prolonged use (Kabat-Zinn, 2003) and document the practice on the *Daily Mindfulness Activity Log* (Appendix E) provided to them with resources and references of the skills and mindfulness practices learned. The counselors utilized the various mindfulness and meditation practices used during the training session as this was sent to all participants via email with the ability to download to multiple devices. Each week, the researcher collected all the questionnaires, scales, and independent practice logs via email. The researcher then plotted the data each week to engage in analysis as immersion in the data provides time and information for change or updates to the intervention, if needed (Kazdin, 2011).

Although the integrated mindfulness counselor training was informed by Kabat-Zinn’s (2013) Mindfulness-Based Stress Reduction, Shapiro et al.’s (2006) *Intention, Attention, Attitude Model*, and Thera’s (1954) meditation practices; there were differences regarding practice duration, training length, method of delivery, and participants’ independent practices as this is common across literature for adaptations to be made when utilizing mindfulness informed practices (Bohecker & Horn, 2016; Buser et al., 2012; Christopher & Maris, 2010; Jain et al., 2007; Shapiro, Schwartz, & Bonner, 1998). For example, MBSR is typically an 8-week training (Kabat-Zinn, 2013); however, the 3-hour integrated training used in this study was to simulate professional development training times used in the field for professional counselors and mainly focused on awareness, self-integration, and self-regulation elements.
Data Analysis

Visual analysis was used to analyze the results of the primary research question. Visual analysis assesses six components of graphed data across phases and participants to identify a causal relationship between constructs as well as the magnitude and strength of that causal relationship. The six components of visual analysis include: (a) level, the mean or line indicating presence of the data points in both phases; (b) data trend or slope, the direction or degree of the data path over time; (c) data variability, the stability of the data; (d) consistency of patterns across similar phases, stability or pattern of data in each phase; (e) immediacy of effect, time and magnitude of an effect after the intervention was implemented; and (f) data overlap, how many data points in one phase overlap or are the same as data points in another phase (Kratochwill et al., 2010). Vertical analysis was also be used to determine that the participants still in the baseline phase did not change once the intervention was introduced to another participant. Additionally, three basic effects, at three different points in time, were needed to determine the effectiveness of the intervention (Ledford & Gast, 2018; Kazdin, 2011).

As mentioned briefly in the data collection procedures, data analysis was done throughout the study. Each week, the researcher received, scored, and plotted the data from the Therapist Appraisal Questionnaire (TAQ; Cooley & Klingler, 1989; Fauth et al., 1999) for each participant. Visual results from the TAQ (Cooley & Klingler, 1989; Fauth et al., 1999) negative stress subscale determined the participants' movement to the intervention condition. Each week the researcher calculated the TAQ (Cooley & Klingler, 1989; Fauth et al., 1999) scores for each participant, plotted the new data points, and began looking for data trends to determine movement into the intervention condition. Once all data were collected for all
participants across all conditions, baseline and intervention, visual analysis continued analyzing data overlap, data trend, level, variability, consistency of patterns across similar phases and immediacy of effect (Kratochwill et al., 2010), in order to determine the effects of the intervention. Three basic effects, or a basic effect for 3 of the 4 participants, indicating a clear change in level, slope, or both level and slope, is needed to determine the effectiveness of the intervention and conclude causation (Kazdin, 2011).

**Threats to Validity**

As with all research inquiries, there are various threats to validity that could affect the results of the investigation. The most common threats to internal validity in single case research design are: (a) history effects, an event occurring at the time or during the experiment/study that could influence the results or outcomes; (b) maturation, any change or growth for the participant that occurs naturally over time; (c) instrumentation, any change in measurements or the way an instrument is used or the validity and relatability of the measure that influences the results of measurement of the construct under inquiry; (d) testing, any change that may be attributed to repeated testing or testing fatigue; and (e) diffusion of treatment, this occurs if the treatment intervention inadvertently enters the baseline stage or during times of the study when it is not supposed to, thus, influencing results of the study (Kazdin, 2011).

Although there are a number of threats to internal validity in single case research designs, the multiple-probes design that was used in this study guards against history and maturation effects as all participants entered the baseline phase at the same time but entered the intervention phase at different times; thus, reducing the likelihood that a history event or maturation effects influenced all four participants in the same way over time. Additionally, the
multiple-probe design also reduces the likelihood of testing effects and extended time in the baseline phase for the latter participants as testing is intermittent in this design and provides periods of time without continuous testing. In regards to diffusion of treatment, this threat was safeguarded against as the inclusion criteria required that all participants did not have formal mindfulness training and the training was only be given to the participant (one-on-one and face-to-face) before entering the intervention condition. Lastly, the main measurement instruments that were used in this study have strong reliability and validity and are the most current and widely used measurements for their respective constructs in the field. However, test-retest reliability for the Countertransference Management Scale (CMS; Perez-Rojas, et al., 2017) and Young Child session rating scale (YCSRS; Duncan et al., 2006) were not reported; therefore, this may be a small limitation. Although there are limitations and threats to internal validity, these threats were accounted for and safeguarded against as best as possible without reducing the external validity of the investigation.

**Treatment Fidelity**

Treatment fidelity or procedural fidelity refers to the strategies used to evaluate the extent in which the intervention was implemented as it was intended or planned (Ledford & Gast, 2018). The treatment fidelity procedures in this study included audiotaping and assessment by two outside observers (doctoral or master’s level counselor education students) of all interventions/training sessions to ensure that the intervention was implemented as planned. Since there were only four training sessions (one per participant), 100% of the trainings underwent treatment fidelity checks and interobserver agreement (IOA) by two outside observers. Upon completion of the checklists, the observers engaged in point-by-point interobserver agreement, indicating
whether a component of the training occurred or not. The two outside observers compared scores for each portion of the intervention and examined the times in which they both marked when I, the implementer, did and did not implement a portion of intervention. The scores were then divided by the total number of areas/components on the checklist and multiplied by 100 to get a percentage. Ideally, the implementation of the treatment should be 100% accurate since I am the implementer; therefore, striving for 100% IOA with 100% Tx and procedural fidelity from the two observers although 80% IOA is acceptable for data collection (Kazdin, 2011).

Social Validity

**Goals.** The goals of this study are supported by literature in the need for more naturalistic, experimental, and integrated CT management approaches to CT manifestations and reactions in session (Hayes, Gelso, & Hummel, 2011; Latts & Gelso, 1995; and Robbins & Jolkovski, 1987). Additionally, the goals of improving the therapeutic relationship, client outcomes, and reducing the negative effects of CT is also supported by literature (Norcross, 2011; Gelso et al., 1995).

**Intervention and Outcomes.** The intervention of an integrated CT management approaches to CT manifestations and reactions in session is supported by the literature (Hayes, Gelso, & Hummel, 2011; Latts & Gelso, 1995; and Robbins & Jolkovski, 1987). In addition, I provided a questionnaire/survey at the end of the study to the participants to gain feedback on the implementation of the intervention. This questionnaire was a combination of a 5-point, Likert-style questionnaire and open-ended questions inquiring about the effectiveness of the intervention in reducing and managing negative
countertransference, ease of self-guided mindfulness practices, and recommendations for improvements on the intervention.

**Ethical Considerations**

It is the researchers’ responsibility to inform the participants of the potential risks and benefits of engaging in this study as well as obtain written consent of the participants acknowledging their understanding of said risks/benefits. I followed the human subjects’ protocol that was approved by the university’s Institutional Review Board (IRB) and ensured the confidentiality of participants and identified the risks and benefits of participating in this study. All research has its risks, whether they are known beforehand or unknown to the researcher. Due to the area of study, managing negative countertransference through an integrated counselor mindfulness training for counselors working with challenging clients, participants may experience vulnerability and heightened awareness of countertransference triggers that they were not aware of previously. Other than the potential of vulnerability and heightened awareness, there are no known risks associated with participating in this research except a slight risk of breach of confidentiality, which remains despite steps that will be taken to protect your privacy. The results of the study may be published or presented at professional meetings, but the participants and clients' identity will not be revealed. Participation in this study was voluntary and the participants were free not to participate or to withdraw at any time, for whatever reason, without negative consequences.

To ensure that this study was conducted with integrity, strong research fidelity, and employ ethical standards throughout the study; the following measures were taken:
1. This study did not begin until approved by the dissertation chair and committee members as well as the Institutional Review Board at the University of South Carolina.

2. Participation in this study was voluntary with the opportunity to stop participation without retaliation or consequence and all participants were provided forms instructing them of these rights.

3. All participants and participant’s clients were deidentified and provided a number/letter combination to ensure confidentiality of participation.

4. All data was stored in a double-locked cabinet and all electronic data will be stored on a password protected computer within a locked room.

5. Consent forms were provided and collected to all participants.

6. Permission to use measures/instruments was obtained before use.

**Chapter Summary**

Chapter three provided a plan for inquiry and outlined the investigation of the effect of an integrated counselor mindfulness training on negative countertransference for counselors working with children exhibiting externalized behaviors and its influence on the therapeutic relationship. The methodology described in this chapter included: (a) research questions and hypotheses, (b) research design, (c) population and sampling procedures, (d) instrumentation, (e) data collection methods, (f) intervention procedure, and (g) data analysis. The following chapters, chapters four and five, will discuss the results of this inquiry and the implications of this study.
CHAPTER FOUR: RESULTS

Chapter Four presents the results of the investigation, addressing each research question and construct measured individually. The purpose of this research study was to investigate the effect of an integrated counselor mindfulness training on negative countertransference for counselors working with children exhibiting externalized behaviors. This investigation utilized a multiple probe, single case research design, across four participants all working in the same setting, to examine the effects of an integrated counselor mindfulness training on counselors’ negative countertransference towards clients who exhibit externalized behaviors in session. Specifically, the elements of countertransference that were examined were negative countertransference feelings and positive feelings of challenge (as measured by, Therapist Appraisal Questionnaire (Cooley & Klingler, 1989; Fauth et al., 1999); countertransference management (as measured by the Countertransference Management Scale (Perez-Rojas, et al., 2017); and negative countertransference behaviors (as measured by The Inventory of Countertransference Behavior (ICB; Friedman & Gelso, 2000). Additionally, the child client’s perspective of the counselor and/or counseling relationship was also examined throughout the study (as measured by the Young Child Session Rating Scale (Duncan et al., 2006).

Population and Sample

The population for this study was beginning mental health counselors, counselors with one to five years of counseling experience as an LPC-A or LPC, who worked with
Children, ages three to nine, that exhibited externalizing behaviors in session (i.e. hitting, kicking, screaming, throwing/breaking things, etc.). Recruitment for this population extended throughout North and South Carolina due to the research design implemented, consistent data collection over a long period of time and feasibility of traveling to implement the intervention face-to-face was required. After two weeks of recruiting via emails and phone calls to various coordinators and counselors of mental health agencies, four counselors working in a therapeutic pre-school responded with interest in participating. Upon completion of the demographic information and *The Inventory of Countertransference Behavior* (ICB; Friedman & Gelso, 2000), all four counselors met the inclusion criteria. Therefore, the sample for this study was comprised of four (N= 4) Licensed Professional Counselor-Associates all working in the same therapeutic pre-school in the North and South Carolina region location.

Single case research design seeks to measure various behaviors or constructs within a homogenous sample to better isolate the independent variable and assist in reducing extraneous variables (Kazdin, 2011). However, diversity in age, gender, ethnicity, and other demographic features are important to researchers as diverse samples better represent the population under examination (Heppner, Wampold, & Kivlighan, 2016). Therefore, this study sought to satisfy both requirements by creating homogeneity among the participants in the areas of: education level, licensure, client population, theoretical orientation, supervision requirements; and place of employment; while also using a more diverse sample based on areas of: age, ethnicity, and gender of the counselors and their clients. At the time of this study, all four counselors reported their highest educational degree as a Master’s degree in mental health counseling, were Licensed Profession
Counselor – Associates with a mean of 1.75 years of counseling experience (range 1-2 years), were receiving supervision for licensure, worked in the same therapeutic preschool with children, ages three to five, exhibiting externalized behaviors, identified cognitive behavioral therapy as their primary theoretical orientation, and had not received formal mindfulness training in the past. The participants consisted of: one, cisgender, White/non-Hispanic male; one, cisgender, White/non-Hispanic female; and two cisgender, African American females. Additionally, all four participants identified as heterosexual with the mean age of 37.75 (range 30-53). All counselors remained active in the study from start to finish, for a total of 14 weeks; however, the last participant entering the intervention phase found new employment two weeks after entering intervention phase, thus, having less time to illustrate a prolonged effect in the intervention phase compared to the other participants.

For this investigation, each participant identified one current client meeting the following criteria: client was between the ages of three to five years old, clients were exhibiting externalized behaviors in session, and the counselors reported having engaged in at least one negative countertransference behavior (rejection of the client, apathy, criticism of the client, complaining about the client, distancing, inappropriate tones, absent-minded, etc…) as measured by The Inventory of Countertransference Behavior (ICB; Friedman & Gelso, 2000). The four clients identified by the counselors in this study were similar in the areas of age and externalized behaviors exhibited in session but varied in ethnicity, gender, and diagnoses. The clients consisted of: one, Bi-racial male; two Bi-racial females, and one, African American male. The clients mean age was 3.25 years old (range 3-4) and the counselors reported the clients engaging in excessive
crying, overactivity, tantrums, impulsivity, obstinance, anger, aggression, destruction of property, hitting, kicking, spitting at others/counselor, throwing objects, screaming, threatening, and inappropriate touching of self and others. The clients’ diagnoses included: Generalized Anxiety Disorder, Parent-Child Relational Problem, Social (Pragmatic) Communication Disorder, Autism Spectrum Disorder, Attention-Deficit/Hyperactivity Disorder, and Child Neglect (American Psychiatric Association, 2013). The clients met with their counselors, scheduled three times a week for 45-minutes per their usual treatment. All clients remained in the study through the entirety of data collection.

Data collection consisted of 14 consecutive weeks beginning at the end of October and ending at the beginning of February. All clients were scheduled to meet with their counselors two to three times per week in accordance with their treatment plans and agency requirements for treatment. There was a total of 32 sessions per client/counselor, 128 sessions total, scheduled during the course of the study. However, due to the multiple probe research design employed, there were three sessions for one participant that were intentionally not measured reducing the 128-session total to 125 total sessions scheduled for measurement. More intentional sessions of no measurement would have occurred for the other participants; however, due to various illnesses or missed sessions by the client/counselor, intermittent data collection was naturally occurring and did not need to be intentionally planned. Therefore, data were collected on 90 sessions out of the total 125 scheduled sessions for session adherence of 72%. All sessions were conducted within the therapeutic pre-school per treatment as usual. If sessions were missed by either the
client or counselor, they were not able to be rescheduled due to counselor availability.

See Table 1.1 for a full breakdown of session attendance by counselor.

Table 4.1 Counseling Session Attendance by Participant

<table>
<thead>
<tr>
<th></th>
<th>Scheduled Sessions</th>
<th>Attended Sessions</th>
<th>% Attended</th>
<th># Missed Sessions due to Client</th>
<th># of Missed Session due to Counselor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lauren</td>
<td>32</td>
<td>26</td>
<td>81.25%</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Cathy</td>
<td>32</td>
<td>30</td>
<td>93.75%</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Steven</td>
<td>29</td>
<td>19</td>
<td>65.55%</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Olivia</td>
<td>32</td>
<td>15</td>
<td>46.87%</td>
<td>10</td>
<td>7</td>
</tr>
</tbody>
</table>

Research Question Results

The results of this study are outlined below beginning with each research question or construct examined during the study. Within each research question or construct examined, the results for each participant are reported. All participants' names have been de-identified and have been replaced with pseudonyms/aliases that are different from the unique identifiers provided during data collection to ensure confidentiality and to illustrate respect for the participants and not minimizing their importance in this study by referring to them as just a number-letter combination.

Primary Research Question

The primary research question examining a causal relationship in this study was, “Does an integrated counselor mindfulness training have an effect on counselor’s feelings of negative countertransference while working with children exhibiting externalized behaviors?” The counselor’s feelings of negative countertransference and positive
feelings of challenge were measured by, *Therapist Appraisal Questionnaire* (Cooley & Klingler, 1989; Fauth et al., 1999). Each week, the participants informed the primary researcher of their anticipated session times with their identified clients, allowing the researcher to know what day and time to send the TAQ (Cooley & Klingler, 1989; Fauth et al., 1999) to the participants. Immediately following the session with the identified client, the participants completed the TAQ (Cooley & Klingler, 1989; Fauth et al., 1999) survey that was sent to their phones to ensure the most current state of the counselors’ feelings towards their clients. The integrated counselor mindfulness training was provided to the counselors in a staggered manner, dependent upon the participants’ baseline stabilities and evidence of a treatment effect for those who had already entered the intervention phase of the study. The primary construct of measurement was the negative countertransference feelings, measured by the negative stress scale on the TAQ (Cooley & Klingler, 1989; Fauth et al., 1999); therefore, the scores on the negative stress scale were used to determine baseline stability and phase changes throughout the study.

The integrated training was a one-time, face-to-face, 3-hour training, and weekly independent practice, integrating mindfulness practices and theoretical tenets of relating to children. All data from the TAQ (Cooley & Klingler, 1989; Fauth et al., 1999) were plotted on graphs for visual analysis; inspecting level, trend, variability, the immediacy of the effect, overlap, and consistency of data patterns across and within phases (Kratochwill et al., 2010). Although there are some statistical measures used in single case research such as Tau-U, points exceeding the mean (PEM), and the percent of nonoverlapping data (PND); these statistical measures only inform overlap and not the other areas of analysis critical for deducing an effect of a treatment/intervention or inferring a causal relationship from the
data. Due to the rigor and repetitive measurement across phases and over time, single case research can infer causal relationships if there are at least three basic effects. Therefore, the results of the visual analysis for each participant's TAQ (Cooley & Klingler, 1989; Fauth et al., 1999) results are presented including the rationale for determining if there was a basic effect present.

Negative countertransference feelings. Lauren’s baseline phase was the shortest (four sessions) among all participants as her negative countertransference feelings, scored on the TAQ (Cooley & Klingler, 1989; Fauth et al., 1999), stabilized first among the four participants. Lauren’s level during the baseline phase was approximately 7; meaning, on average, Lauren reported her negative countertransference feelings as a 7 out of 40 on the TAQ (Cooley & Klingler, 1989; Fauth et al., 1999) during baseline. However, Lauren's slope/trend of her data was steadily moving upward through her baseline phase, showing little variability and a strong pattern of continued higher scores of negative feelings and stress over time. Therefore, due to the stable pattern of the increasing slope in the baseline phase, moving the opposite direction of the intended effects of the training;

Lauren moved into the intervention phase after four sessions with her client. Using the last three data points in baseline for comparison, there was an immediate change in level and slope after Lauren engaged in the intervention training. Lauren’s level fell from approximately 7 in baseline to approximately 2 in the intervention phase, with a stable and slightly decreasing slope, projecting a continued trend of decreasing feelings of negative countertransference. Lauren’s data were fairly stable and illustrated consistent patterns over time in both phases. Lauren did have one high data point in her intervention phase, overlapping with data points in her baseline phase after an extremely
challenging session in which the client’s behaviors were more severe than she previously had endured. However, through continued independent mindfulness practices throughout her intervention phase, Lauren’s score immediately dropped and remained consistently lower throughout the rest of the study. Lastly, Lauren only had two overlapping data points between the baseline and intervention phases, one being the smallest score in baseline and one being the biggest score in the baseline phase. Overall, Lauren’s scores in her baseline phase compared to her scores in the intervention phase, in all areas of visual analysis, illustrated a small basic effect as she reported higher scores of sadness, disappointment, and worry in the baseline phase to reporting very little or none of those feelings after receiving the intervention.

Following the demonstration of an intervention effect in Lauren's data, Cathy was the next participant to move into the intervention phase. Cathy's baseline data was a bit variable at first during her first four sessions but leveled out over time. Cathy's client missed two consecutive sessions during the baseline phase due to illness, so no data was collected during that week. However, this pattern of intermittent data collection is a component of the multiple probe single case research design protocol; however, much of the intermittent measurement in this study occurred naturally between the clients’ and counselors’ varying needs throughout the study. Cathy’s level during the baseline phase was approximately 12 with an increasing slope steadily trending upward towards more negative countertransference feelings. Similar to Lauren’s data, Cathy’s last four data points of baseline illustrated little variability and a strong consistent pattern of continued higher scores of negative feelings over time. Thus, with movement in the opposite direction of the intended effects of the training and a small, visually apparent intervention...
effect in Lauren’s data, Cathy moved into the intervention phase after eight sessions with her client.

Using the last three data points in Cathy’s baseline phase for comparison, there was an immediate change in level and slope after Cathy engaged in the intervention. Cathy’s level fell from approximately 12 in baseline to approximately 4 in the intervention phase with a stable and flat slope, projecting a continued trend of her currently low feelings of negative countertransference experienced during the intervention phase. Cathy’s data were a bit variable during the beginning of baseline and intervention but leveled out and became more stable in both phases over time; illustrating consistent patterns within and between phases. Cathy did have a one high data point during her intervention phase due to an event in session with her client; however, her scores immediately dropped and remained steadily lower throughout the study with some variability. Lastly, Cathy only had two overlapping data points between the baseline and intervention phases, one being the lowest score in baseline. Overall, Cathy’s scores in her baseline phase compared to her scores in the intervention phase in all areas of visual analysis illustrated a small basic effect as she reported higher scores of anger, sadness, disappointment, worry, fear, anxiety, guilt, and lower confidence in the baseline phase to reporting very little or none of those feelings after receiving the intervention.

Following the demonstration of an intervention effect in Cathy's data, Steven was the next participant to move into the intervention phase. Steven's baseline data was fairly stable throughout the baseline phase and both intentional and natural intermittent measurement was employed. Unlike Lauren and Cathy's baseline data, Steven had four breaks in data collection (1 planned and 3 naturally occurring) due to one planned break
and 3 breaks in which sessions were missed by both the client and counselor due to illness or absence. Steven’s level during the baseline phase was approximately 6 with an increasing slope steadily trending upward towards more negative countertransference feelings. Similar to Lauren and Cathy’s data, Steven’s last four data points of baseline illustrated strong consistent pattern or upward trend of continued higher scores of negative feelings over time but with some variability. The last few data points of Steven’s baseline data were the highest scores he reported throughout the study increasing from an average of 5 to an 11 before moving to the intervention phase. Thus, with movement in the opposite direction of the intended effects of the training and a small, visually apparent intervention effect in Cathy’s data, Steven moved into the intervention phase after 13 sessions with his client.

Using the last three data points in Stevens's baseline phase for comparison, there was an immediate change in level and slope after Steven engaged in the intervention/training. Steven's overall level fell from approximately 6 in baseline to approximately 5 in the intervention phase with a stable and flat slope, projecting a continued trend of his current lower feelings of negative countertransference experienced during the intervention phase. Steven's overall level change is smaller than Lauren and Cathy's overall level change; however, Steven's overall scores on the TAQ (Cooley & Klingler, 1989; Fauth et al., 1999) were fairly low to start; thus, limiting the potential magnitude in change possible. However, even with lower scores in the baseline phase, Steven's data still illustrated a clear and visual change in level and slope over time and across phases. Lastly, Steven had five overlapping data points between the baseline and intervention phases, which is higher than the other participants but also may be due to
already low scores in the baseline phase. Although Steven's data had a higher level of overlap compared to the other participants, his changing levels of trend and slope illustrate an intervention effect. Overall, Steven’s scores in his baseline phase compared to his scores in the intervention phase in most areas of visual analysis illustrate a small basic effect as he reported higher scores of fear, sadness, disappointment, and lower confidence in the baseline phase to reporting very little or none of those feelings after receiving the intervention.

Following the demonstration of an intervention effect in Steven’s data, Olivia was the next and final participant to move into the intervention phase. Olivia’s baseline data was fairly stable but not as consistent as the others due to high rates of missing sessions. Therefore, Olivia only had one area in which she saw her client two or more times consecutively due to client and counselor illnesses and absences. Although this study employed a multiple probe single case research design incorporating a pattern of intermittent data collection; there were more missed sessions than sessions in which data was collected; therefore, reducing the impact of her results on this study. However, there was significant visual change in Olivia’s data. Olivia’s level during the baseline phase was approximately 5 with an increasing slope steadily trending upward towards more negative countertransference feelings. Similar to Steven’s data, Olivia’s last four data points of baseline illustrated an upward trend of continued higher scores of negative feelings over time but with some variability. Thus, with movement in the opposite direction of the intended effects of the training and a small, visually apparent intervention effect in Steven’s data, Olivia moved into the intervention phase after 12 sessions with her client.
Using the last three data points in Olivia’s baseline phase for comparison, there was a small but immediate change in level and slope after Olivia engaged in the intervention/training. Olivia’s level fell from approximately 5 in baseline to approximately 2 in the intervention phase with a stable, negative slope, projecting a continued trend of lower feelings of negative countertransference. Olivia’s data were fairly stable during baseline and intervention but were not as consistently measured; however, there was still consistent patterns within and between phases. Olivia’s overall level change is smaller than the other participants overall level change; however, Olivia’s overall scores on the TAQ (Cooley & Klingler, 1989; Fauth et al., 1999) were fairly low to start; thus, limiting the potential magnitude in change possible. However, even with lower scores in baseline and inconsistent measurement, Olivia’s data still illustrated a clear and visual change in level and slope over time and across phases. Lastly, Olivia had three (all of her data in the intervention phase) overlapping data points between the baseline and intervention phases, which is not ideal but again also may be due to already low scores in the baseline phase. Although Olivia’s data had a high level of overlap, her change in levels of trend and slope illustrate a small intervention effect. Overall, Olivia’s scores in her baseline phase compared to her scores in the intervention phase in most areas of visual analysis illustrate a small basic effect as she reported higher scores of fear, worry, anxious, guilty, and lower confidence in the baseline phase to reporting very little or none of those feelings after receiving the intervention.

Vertical analysis was conducted throughout the study for all participants in all phases. Vertical analysis was used to ensure there was no change to participants in baseline while other participants received the intervention (Kazdin, 2011). Multiple probe single case
research design employs concurrent baseline phases and staggering intervention phases for all participants. The use of concurrent baselines and staggering the intervention phases across all participants safeguards against extraneous variables influencing the data without knowledge to the researcher. Through vertical analysis, the data was analyzed daily as new data points were plotted to ensure that the participants in baseline were not responding in ways similar to the participants in intervention. If this was so, there may have been an extraneous variable or threat to validity causing changes in the data; thus, reducing the confidence that the intervention investigated in this study actually provided the change noted in the data. Without vertical analysis, concurrent baselines, and staggering of the intervention; the effect of the intervention cannot be clearly measured and a causal relationship cannot be determined with fidelity. Through consistent vertical analysis, there were no changes among the four participants in this study during baseline or intervention that proved questionable or appeared to influence the data other than the intervention training. Therefore, through vertical and visual analysis, four basic effects were determined from this data indicating a small intervention effect of the integrated training on reducing counselors' negative countertransference feelings towards their clients exhibiting externalized behaviors. The TAQ (Cooley & Klingler, 1989; Fauth et al., 1999) results for all four participants' negative countertransference feelings are displayed in Figure 4.1.

Positive feelings of challenge. Decisions to move participants from the baseline phase to the intervention phase was based on the baseline stability and intervention effect of the TAQ (Cooley & Klingler, 1989; Fauth et al., 1999) results for the negative countertransference feelings subscale. However, the participants were also completing the challenge scale indicating their levels of challenge through assessing their feelings of
Figure 4.1 Total occurrences of negative countertransference feelings for each participant towards their clients.
happiness, eagerness, energy, excitement, exhilaration, hopefulness, and pleasing. Although this scale was not the main focus of the research question and intervention training, the intervention training appeared to affect these scores for 3 out of 4 of the participants according to the visual analysis indicating a small causal relationship as a byproduct of reducing the negative countertransference feelings. The results for each participant are as follows.

Similar to the negative countertransference feelings results, Lauren's baseline phase was the shortest (four sessions) among all participants. Lauren's negative countertransference feelings, scored in the TAQ (Cooley & Klingler, 1989; Fauth et al., 1999), stabilized first among the four participants; therefore, moving her into the intervention phase. As Lauren's negative countertransference feelings began to increase over time, her positive feelings towards the client began to steadily decrease as well. This is clearly seen through her decreasing slope and data trend through her first four points of her baseline phase. Lauren's level during the baseline phase was approximately 20; meaning, on average, Lauren reported her positive feelings towards the client as a 20 out of 30 on the TAQ (Cooley & Klingler, 1989; Fauth et al., 1999) during baseline. However, Lauren's slope/trend of her data was steadily moving downward through her baseline phase, showing little variability and a strong pattern of continued lower scores of positive feelings and stress over time. Therefore, similar to her negative feelings reported but in the opposite direction, Lauren's data trend was moving in the opposite direction of the intended effects of the training. Lauren moved into the intervention phase after four sessions with her client.
Using the last three data points in baseline for comparison, there was a small change in level and more drastic change in slope after Lauren engaged in the intervention training; however, this change was not as immediate as the negative countertransference scores and occurred after the third session in the intervention phases. Lauren's level fell from approximately 20 in baseline to approximately 18 in the intervention phase indicating an overall experience of fewer positive feelings towards her client during the intervention phase compared to her baseline phase. Although this is the opposite direction of level change desired; the slope of Lauren's data indicated a clear change during the intervention phase as it became more stable and slightly increasing, which denoted a continued trend in increased positive feelings than the negative trend reported during the baseline phase.

Lauren's slope changed from a negative slope, or trending downward, during baseline to a flat or slightly increasing slope during the intervention phase indicating a small intervention effect. Lauren's data were variable through her intervention phase indicating more movement in her positive feelings towards her client. Lastly, the majority of Lauren's data in her intervention phase overlapped with her data in the baseline phase, which would be predicted due to only a small change in her level between phases. Overall, Lauren's scores in her baseline phase compared to her scores in the intervention phase indicated a clear change in slope which illustrated a small basic effect as she reported lower scores of happiness, excitement, exhilaration, and energy in the baseline phase to reporting higher scores of those feelings after receiving the intervention.

Following the demonstration of an intervention effect in Lauren's negative countertransference feelings scores, Cathy was the next participant to move into the
intervention phase. Similar to her negative feelings scores, Cathy's baseline data were highly variable during her first four sessions; however, her data stabilized over time and always illustrated a negative trending slope. Similar to Lauren's data, as Cathy's negative feelings towards her client increased, her positive feelings decreased. Cathy's client missed two sessions during the baseline phase, which is similar to the intermittent data collection pattern for the negative countertransference feelings data collected as both scales were assessed at the same time.

Cathy's level during the baseline phase was approximately 10 with a decreasing slope steadily trending downward towards fewer positive feelings towards her client. Similar to Lauren's data, Cathy's last four data points of baseline illustrated little variability and a strong consistent pattern of continued lower scores of positive feelings over time. Therefore, similar to her negative feelings reported but in the opposite direction, Cathy's data trend was moving the opposite direction of the intended effects of the training; therefore, Cathy moved into the intervention phase after eight sessions with her client.

Based on the last three data points in the baseline phase for comparison, there was a change in level and more drastic change in slope after Cathy engaged in the intervention training. Both the change in level and slope were immediate as it occurred after the first session in the intervention phases. Cathy's level increased from approximately 10 out of 30 in baseline, to approximately 13 in the intervention phase indicating an overall experience of higher positive feelings towards her client during the intervention phase compared to her baseline phase. Additionally, the slope of Cathy's data indicated a clear change during the intervention phase as it became more stable with
a slight increasing trend over time, which denoted a continued trend of more positive feelings over time compared to the negative trend reported during the baseline phase. Cathy’s slope changed from a negative slope, or trending downward, during baseline to a slightly increasing slope during the intervention phase indicating a small intervention effect. Cathy’s data were variable throughout her intervention phase indicating more movement in her positive feelings towards her client but her data remained generally within the higher level than her baseline phase. Lastly, the majority of Cathy’s data in her intervention phase overlapped with two data points in the baseline phase, which could be due to outlier scores that did not appear to fit her overall trend of the baseline phase. Overall, Cathy’s scores in her baseline phase compared to her scores in the intervention phase indicated a small but clear change in level as well as a clear change in slope which illustrated a small basic effect as she reported lower scores of happiness, excitement, exhilaration, energy, and hopefulness in the baseline phase to reporting higher scores of those feelings after receiving the intervention.

Following the demonstration of an intervention effect in Cathy’s negative countertransference feelings scores, Steven was the next participant to move into the intervention phase. Steven’s scores on the positive feelings and challenge subscale did not show very much change between his baseline and intervention phases. Steven’s baseline data was fairly variable as it was during his intervention phase; indicating consistency across phases. Steven’s level during the baseline phase was approximately 18 out of 30 with a flat and steady slope. Steven’s last three data points of baseline illustrated little variability and a strong consistent pattern of stable positive feelings with
a flat projected slope over time. Steven moved into the intervention phase after 13 sessions with his client.

Based on the last three data points in the baseline phase for comparison, there was little change in level and little to no change slope after Steven engaged in the intervention training. Since there was little to no change in either level or slope/trend; there was no immediacy of an effect to report after the baseline phase. Steven's level increased from approximately 18 out of 30 in baseline, to approximately 19 in the intervention phase indicating an overall similar experience but slightly higher positive feelings towards his client during the intervention phase compared to her baseline phase. Unlike the other participants, the slope of Steven's data did not indicate a clear change during the intervention phase as it continued with the same, flat, stable path established during the baseline phase. Due to the lack of change in level and little to no change in his slope, there did not appear to be an intervention effect on Steven's positive feelings towards his client. Steven's data were variable throughout his intervention phase and he recorded fewer data points due to the staggering of participants entering the intervention phase and his missed sessions by he and his client. Therefore, a stable or clear pattern or trend was difficult to identify in the data reported. Lastly, almost all of Steven's data in his intervention phase overlapped with his data points in the baseline phase, which would be expected as his level only changed slightly and his slope did not change across phases. Overall, Steven's scores in his baseline phase compared to his scores in the intervention phase did not indicate a clear change in level or slope; therefore, a basic effect could not be determined for the intervention.
Following the demonstration of an intervention effect in Steven’s negative countertransference feelings scores, Olivia was the next participant to move into the intervention phase. Similar to her negative feelings scores, Olivia’s baseline data were fairly variable and had a lot of missing sessions due to client and counselor illness and absence during her baseline phase. Although Olivia’s baseline data is sparse and a bit variable, a clear negative slope or trend was identified. Similar to Lauren and Cathy’s data, as Olivia’s negative feelings towards her client increased, her positive feelings decreased. Olivia’s level during the baseline phase was approximately 10 with a decreasing slope steadily trending downward towards fewer positive feelings towards her client. Olivia’s last four data points of baseline illustrated little variability and a strong consistent pattern of continued lower scores of positive feelings over time. Therefore, similar to her negative feelings reported, but in the opposite direction, Olivia’s data trend was moving the opposite direction of the intended effects of the training; therefore, Olivia moved into the intervention phase after 12 sessions with her client.

Based on the last three data points in the baseline phase for comparison, there was a significant change in level and a clear, drastic change in slope after Olivia engaged in the intervention training. Both the change in level and slope were immediate as it occurred after the first session in the intervention phases. Olivia's level increased from approximately 10 out of 30 in baseline, to approximately 18 in the intervention phase indicating an overall experience of higher positive feelings towards her client during the intervention phase compared to her baseline phase. Additionally, the slope of Olivia's data indicated a clear change during the intervention phase as it became more stable with a small increasing trend over time, which denoted a continued trend of more positive
feelings over time compared to the negative trend reported during the baseline phase. Olivia’s slope changed from a negative slope, or trending downward, during baseline to a slightly increasing slope during the intervention phase indicating a small intervention effect. Lastly, Olivia has no overlapping data across her baseline and intervention phases. Overall, Olivia’s scores in her baseline phase compared to her scores in the intervention phase indicated a clear change in level as well as a clear change in slope illustrating a small basic effect as she reported lower scores of happiness, excitement, exhilaration, energy, and hopefulness feelings in the baseline phase to reporting higher scores of those feelings after receiving the intervention. Although Olivia’s data illustrated a significant change in level and slope visually; due to the inconsistent measurement and few data points reported throughout the study, only a small basic effect can be determined.

Vertical analysis was also conducted for this construct throughout the study for all participants in all phases. Through vertical analysis, the data was analyzed daily as new data points were plotted to ensure that the participants in baseline were not responding in ways similar to the participants in intervention. Through consistent vertical analysis, there were no changes among the four participants in this study during baseline or intervention that proved questionable or appeared to influence the data other than the intervention training. Therefore, through vertical and visual analysis, three of four participants illustrated a small basic effect; indicating a small intervention effect of the training on increasing counselors’ positive feelings towards their clients exhibiting externalized behaviors as displayed in Figure 4.2.

Secondary Research Question One

To answer the secondary research question “Does an integrated counselor
Figure 4.2 Total occurrences of positive feelings of challenge for each participant towards their clients.
mindfulness training influence the counselor’s ability to manage negative countertransference while working with children exhibiting externalized behaviors as measured by the *Countertransference Management Scale* (Perez-Rojas, et al., 2017)?”

the participants’ supervisors completed the *Countertransference Management Scale* (CMS; Perez-Rojas, et al., 2017) after each supervision session during the entirety of the investigation. Each week, the supervisors were sent a link via email to the survey entered into SurveyMonkey. The supervisors only completed the survey that week if they met with their supervisee for clinical supervision.

**Countertransference management.** Based on the number of responses and/or completed CMS (Perez-Rojas, et al., 2017) surveys throughout the study, on average the counselors engaged in clinical supervision 2.75 times in 14 weeks. Two counselors engaged in clinical supervision three times, one engaged in clinical supervision four times, and one participant engaged in clinical supervision one time throughout the course of the study. Additionally, upon completion of the study, the counselors reported that the topic of countertransference and feelings towards their clients was not a popular topic of supervision; therefore, the supervisors may not have been able to speak to the level of countertransference management of their supervisee. Due to low reporting and inability to speak on the topic area of countertransference feelings and behaviors, the results of the CMS (Perez-Rojas, et al., 2017) were inconclusive. The average scores for all four participants on the CMS (Perez-Rojas, et al., 2017) was a 3.8; a score of 3 indicating “Neither agree nor Disagree” per the supervisors’ reports. Although the scores on the CMS (Perez-Rojas, et al., 2017) were inconclusive, the participant who engaged in four supervision sessions did observe a steady increase in countertransference management
abilities in both subscales of "Understanding Self and Client" and "Self-Integration and Self-Regulation". Therefore, this question was not answered by this investigation. Figure 4.3 illustrates the average scores for each participant during each supervision session.

![Overall CMS Scores of All Participants Across Sessions](image)

**Secondary Research Question Two**

To answer the second secondary research question, “Does an integrated counselor mindfulness training influence the client’s perception of the counseling relationship in session, as measured by the Young Child Session Rating Scale (Duncan et al., 2006)?”, the identified child client working with the counselors completed the *Young Child Session Rating Scale* (Duncan et al., 2006) once a week through the entirety of the study in the attempt to gain feedback from another participant in the counseling relationship other than the counselor and supervisor. However, due to the ages of clients (3-4 years), these results were inconclusive. Each week the child was provided the *Young Child Session Rating Scale* (Duncan et al., 2006) which displays four faces with different emotions for the child to select indicating his/her feelings about the counselor that week.
However, due to the age and/or responsiveness of the child clients, the indication on the scales were not legible. Therefore, this question was not answered by this investigation.

**Countertransference Behavior**

Although the reduction of countertransference behaviors was not an initial research question, the counselors and supervisors completed the negative countertransference behavior scale within *The Inventory of Countertransference Behavior* (ICB; Friedman & Gelso, 2000) before beginning the study and upon completion of the study. This secondary probe was given in a pre-test/post-test fashion, once before intervention and once after the intervention, to see if any changes in negative countertransference behaviors occurred per the counselors and supervisors report. This survey was only used to determine if the counselors were engaging in negative countertransference behaviors, scoring a two or higher on any of the questions, and not to what extent or the frequency the behavior was being enacted in session as inclusion criteria for the study. However, there was a noticeable change in the number of negative countertransference behaviors the counselors engaged in prior to the intervention training and after the intervention training.

Three of the four participants reported engaging in fewer negative countertransference behaviors after the intervention training. Additionally, three of the four supervisors also reported noticing reduced negative countertransference behaviors by the counselors in session. However, the biggest difference noted was the number of negative countertransference behaviors reported by the counselors of themselves and the supervisors of the counselors. Similar to the trend with the *Countertransference Management Scale* (CMS; Perez-Rojas, et al., 2017) data, the supervisors did not appear
to be as connected to the counselors’ experiences with negative countertransference. In total, the counselors reported engaging in 29 negative countertransference behaviors in session prior to the intervention and their supervisors reported that the counselors engaged in only 8 prior to the intervention. Similarly, the counselors reported a reduction of countertransference behaviors from 29 to 15 after the intervention training; while the supervisors reported the counselors’ reduction of negative countertransference behaviors from 8 to 5 after the intervention training (Table 4.2 & Figure 4.4). Lastly, the average frequency (1-Little to No Extent, 3- To Moderate Extent, 5- To a Great Extent) in which the negative countertransference behaviors were expressed in session by the counselors also reduced, although that was not the intention for the inclusion criteria (Table 4.3). Therefore, it appears that there may be a small trend between the intervention training and reduction of negative countertransference behaviors; however, this will need to be further examined in the future with more participants and with more rigor. Tables 4.2, 4.3, and Figure 4.4 are below.

![Number of Negative CT Behaviors Expressed in Session](image)

**Figure 4.4 Number of Negative CT Behaviors Reported in Session**
### Table 4.2 Number of Negative CT Behaviors Expressed in Session

<table>
<thead>
<tr>
<th>Participant/Supervisor</th>
<th>Before Intervention</th>
<th>After Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lauren</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Lauren’s Supervisor</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Cathy</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Cathy’s Supervisor</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Steven</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Steven’s Supervisor</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Olivia</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Olivia’s Supervisor</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

### Table 4.3 Average Score on Inventory of Countertransference Behavior Questionnaire

<table>
<thead>
<tr>
<th>Participant/Supervisor</th>
<th>Before Intervention</th>
<th>After Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lauren</td>
<td>2.45</td>
<td>1.45</td>
</tr>
<tr>
<td>Lauren’s Supervisor</td>
<td>1.81</td>
<td>1.54</td>
</tr>
<tr>
<td>Cathy</td>
<td>1.64</td>
<td>1.27</td>
</tr>
<tr>
<td>Cathy’s Supervisor</td>
<td>1.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Steven</td>
<td>1.55</td>
<td>1.36</td>
</tr>
<tr>
<td>Steven’s Supervisor</td>
<td>1.18</td>
<td>1.00</td>
</tr>
<tr>
<td>Olivia</td>
<td>2.45</td>
<td>1.55</td>
</tr>
<tr>
<td>Olivia’s Supervisor</td>
<td>1.09</td>
<td>1.00</td>
</tr>
</tbody>
</table>
Independent Mindfulness Practice

The second component of the integrated counselor mindfulness training included the participants’ independent mindfulness practice. Upon completion of the 3-hour training, all participants received multiple copies of the *Daily Mindfulness Activity Logs* (Appendix E) to record their daily mindfulness practices each day throughout their time in the intervention phase. On the logs, the participants reported how likely they were to engage in at least one daily mindfulness practice, the type(s) of mindfulness practices they engaged in, the duration of the mindfulness practices, indications of any physical, cognitive, and emotional awareness, and any insights or reflections after or during the practice. On average, all participants engaged in mindfulness practice 4.68 days per week. Specifically, on average Lauren engaged in mindfulness practices 3.45 days per week for 16.95 minutes per week for 11 weeks; Cathy engaged in mindfulness practices 4.5 days per week for 71.4 minutes per week for 9 weeks; Steven engaged in mindfulness practices 3.8 days per week for 9.4 minutes per week for 5 weeks; and Olivia engaged in mindfulness practices 7 days per week for 12 minutes per week for 1 week. Additionally, Lauren and Cathy utilized all five types of mindfulness practices discussed in the training during their independent practices (guided meditation, music meditation, body scans, 1-minute meditations, and diaphragmatic breathing practice); while Steven and Olivia utilized only the 1-minute meditations and diaphragmatic breathing practices. Regarding insights and reflections, all participants reported feeling increased awareness of their bodies, awareness of feelings and emotions, increased mood, feeling less distracted, and feeling more intentional. Lastly, the participants reporting more consistent and longer duration of independent mindfulness practices (Lauren, Cathy, and Olivia) also exhibited
greater intervention effects for both negative countertransference feelings and positive feelings of challenge (See Figures 4.1 and 4.2).

**Treatment Fidelity**

Treatment fidelity, also known as treatment integrity, is used in single case research when data are collected during the intervention phase only and can be described as the degree of adherence between the planned intervention procedures to the actual implemented intervention procedures (Ledford & Gast, 2018). Variability in intervention implementation across participants may result in variability of outcomes and a reduction in reliability of the study's results (Kazdin, 2011). To establish strong treatment fidelity, all intervention trainings (4) were audio recorded between the primary researcher/implementer and the counselors. All four audio recordings were then reviewed by two outside observers separately. The two outside observers were provided a *Treatment Fidelity Checklist* or rating sheet with the exact order and procedures of the intervention to complete after reviewing the audio recording of each session (Appendix G). Upon completion of the checklist, the observers, independently calculated their own treatment fidelity percentage by dividing the number of observed procedures completed by implementer by the number of planned procedures and then multiplying by 100.

To ensure rigor and high adherence to intervention implementation, interobserver agreement (IOA) was utilized between observers. Interobserver agreement is not required for treatment fidelity processes; however, IOA is a staple of single case research, typically used to assess the accuracy of observational measurement of the variable under investigation (Kazdin, 2011). Typically, IOA is completed on 20-33% of observations per phase and requires a minimum of 80% IOA to ensure valid results (Ledford & Gast,
However, since this study did not utilize observational measurement of the primary dependent variable, IOA was not used in this way. Instead, IOA was used to ensure rigor during the assessment of treatment fidelity. Therefore, IOA was collected on 100% of all intervention trainings. The IOA for all four trainings was 100% as both observers noted 100% adherence to the intervention protocols in three of the four intervention trainings and 94% adherence to the intervention protocols in the one training; which resulted in 98.5% overall treatment fidelity across all intervention implementations. The one training resulting in a 94% intervention adherence was due to running out of time during the first training with Lauren in which the closing poem was not read to end the training.

**Social Validity**

Social validity is a key component of single case research as applied research strives to investigate socially important goals, interventions/treatments, and outcomes to be socially for the participants of interest (Kazdin, 2011). Additionally, if the interventions/treatments are more acceptable and easily implemented, they will be more likely to be used by others in the future (Kazdin, 2011). The social validity of this investigation was assessed through a *Post-Intervention Follow-Up Questionnaire* that was created by the researcher addressing the following elements: (a) effectiveness of the intervention in improving the counselors’ work with children exhibiting externalizing behaviors and other clients, (b) ease of participation in the intervention training, (c) likelihood of continual use of learned intervention practices, and (d) replication of the intervention training or similar trainings. According to the participants, all four participants reported that they: (a) liked the intervention very much, (b) would engage in
the intervention training again, (c) would recommend the intervention training to other professionals, (d) were interested in learning more about the topics covered in the training, and (e) saw positive carry over from the training to their other clients as the training helped provide a more intentional and focused session with their clients.

Additionally, three participants reported seeing positive client change after engaging in the intervention training as evidenced by the clients being more receptive to the counselors, the clients having improved emotional and verbal expression, and shorter periods of regressed behaviors in session; while one counselor did not report noticing any changes in the identified client. Also, the participants reported feeling less critical of their clients, more intentional in session, open, less reactive, and more aware of how their feelings influenced their clients. In regard to the structure and implementation of the training, all four participants reported the time frame and structure of the intervention training was sufficient and not too long and one participant mentioned introducing shorter, booster sessions throughout the study to complement the skills and practices learned. Lastly, all participants engaged in regular, independent mindfulness practice as evidenced by their daily mindfulness logs at least 3 times per week. The most used mindfulness practice that was often used multiple times per day and throughout the week was the mindful minute exercise with the body scan recording as the second most used practice.

**Chapter Summary**

Chapter Four presented the results of the data analyses utilized in this investigation. Areas of analysis included: (a) visual analysis of the data, (b) treatment fidelity, and (c) social validity of the intervention training. Chapter Five includes a
discussion of the results, areas and recommendations of future research, implications for counselor preparation, counselor educators, counselors, and supervisors and limitations of the study.
CHAPTER FIVE: DISCUSSION

Chapter Five includes a summary of the investigation including the purpose, research methodology, and results. Conclusions drawn from this investigation are based on the results and hypotheses and will be presented and discussed in this chapter. The chapter concludes with a discussion of; (a) study limitations; (b) implications for counselor education, professional counselors, and supervisors; and (c) areas of future research.

Summary of the Study

The purpose of this research study was to investigate the effect of an integrated counselor mindfulness training on negative countertransference for counselors working with children exhibiting externalized behaviors. Specifically, the integrated counselor mindfulness training utilized in this study included; (a) mindfulness training and practice (Kabat-Zinn, 2013) and (b) education on the theoretical tenets of relating to children (Landreth, 2012). In addition, this study also examined the counselors’ ability to manage negative countertransference while working with children exhibiting externalized behaviors as measured by the Countertransference Management Scale (Perez-Rojas, et al., 2017) as well as the client’s perception of the counseling relationship in session, as measured by the Young Child Session Rating Scale (Duncan et al., 2006). More specifically, this investigation analyzed the effect of the integrated counselor mindfulness training on the counselors' feelings of negative countertransference towards their child
client exhibiting externalized behaviors (i.e. hitting, kicking, screaming, throwing/breaking things, etc…).

Working with challenging populations in a clinical setting can be stressful (Hastings, 2002). Challenging populations can include working with children as children communicate differently than adults due to varying developmental levels and cognitive processing (Landreth, 2012). Often, children use behaviors as a way of communicating and children who have endured a significant life event (trauma, change, loss, etc…), may exhibit externalized behaviors as a way of communicating their feelings or needs (Gerson & Rappaport, 2012). However, it appears that the behaviors children use for communication are the same behaviors that induce high levels of counselor stress leading to counselors engaging in negative thoughts and feelings towards their clients (Keil & Price, 2006; Linn-Walton & Pardasani, 2014).

Due to the lack of literature and time spent in the counseling profession on managing negative countertransference or negative feelings towards clients, counselors and counselors-in-training are struggling with acknowledging, accepting, and working through their negative feelings; thus, leading to inappropriate treatment approaches (Guest at al. (In review); Linn-Walton & Pardasani, 2014). Some of the inappropriate treatment approaches identified by Linn-Walton and Pardasani (2014) and Guest at al. (In review) are: (a) blaming the client for contributing to the feelings of dislike; (b) labeling clients as difficult to work with; (c) minimizing empathic responses to clients; (d) instilling fear in clients; (e) using intimidation to control client’s behaviors, (f) shortened session times, (g) labeling clients as a bully, (h) walking out of session and leaving the child alone, and (i) believing the client needs to have his “butt beat”. Although not often
talked about (Kottler & Uhlemann, 1994), counselor’s do experience feelings of negative countertransference and unchecked or unmanaged countertransference can lead to countertransference manifestations or harm to the client and/or therapeutic relationship (Strupp, 1980). Therefore, one way of managing countertransference is through mindfulness practices.

Mindfulness practices assist with minimizing stress responses of anger, fear, and avoidance (i.e. negative countertransference behaviors) when feeling exhausted, threatened, or distracted (Napoli, 2001). However, Hayes, Gelso, and Hummel (2011) reported that mindfulness strategies alone are not as effective in managing countertransference as a combined approach including both mindfulness approaches and an educational/theoretical framework. Therefore, it appears that more training may be helpful to counselors in managing negative countertransference and strengthening the therapeutic relationship. Thus, this study attempted to provide a solution measuring the effects of an integrated counselor mindfulness training combining both mindfulness training and practice and education on the theoretical tenets of relating to children to assist in managing and/or reducing counselors’ feelings of negative countertransference towards their child clients exhibiting externalized behaviors.

**Participant Demographics**

The sample for this study included four Licensed Professional Counselor Associates working in a therapeutic preschool in the southeastern region of the United States with children, ages three to five, who exhibit externalized behaviors in session. All four participants worked in the same therapeutic preschool to assist in reducing extraneous variables or outside influences affecting the data. At the time of this study, all
four counselors reported their highest educational degree as a Master's degree in mental health counseling and had a mean of 1.75 years of counseling experience (range 1-2 years). Additionally, all participants were receiving supervision for licensure, identified cognitive behavioral therapy as their primary theoretical orientation, and had not received formal mindfulness training in the past. The participants consisted of: one, cisgender, White/non-Hispanic male; one, cisgender, White/non-Hispanic female; and two cisgender, African American females. Additionally, all four participants identified as heterosexual and had a mean age of 37.75 (range 30-53). All counselors remained active in the study from start to finish, for a total of 14 weeks.

Each participant identified one current client, between the ages of three to five years old, who exhibited externalized behaviors in session and the counselor admitted engaging in countertransference behaviors (rejection of the client, apathy, criticism of the client, complaining about the client, distancing, inappropriate tones, absent-minded, etc…) in session with this client as measured by The Inventory of Countertransference Behavior (ICB; Friedman & Gelso, 2000). The four clients identified by the counselors in this study were similar in the areas of age and externalized behaviors exhibited in session but varied in ethnicity, gender, and diagnoses. The clients consisted of: one, Bi-racial male; two, Bi-racial females, and one, African American male. The clients mean age was 3.25 years old (range 3-4) and the counselors reported the clients engaging in excessive crying, overactivity, tantrums, impulsivity, obstinance, anger, aggression, destruction of property, hitting, kicking, spitting at others/counselor, throwing objects, screaming, threatening, and inappropriate touching of self and others. The clients’ diagnoses included: Generalized Anxiety Disorder, Parent-Child Relational Problem, Social
(Pragmatic) Communication Disorder, Autism Spectrum Disorder, Attention-Deficit/Hyperactivity Disorder, and Child Neglect (American Psychiatric Association, 2013). The clients met with their counselors scheduled three times a week for 45-minutes per their usual treatment. All clients remained in the study through the entirety of data collection. Data collection consisted of 14 consecutive weeks beginning at the end of October and ending at the beginning of February.

**Discussion of Results**

The results of this study, presented in Chapter Four, are further discussed below. Additionally, the results and findings of this study are compared to the other research on countertransference, negative countertransference, countertransference management and mindfulness and countertransference as outlined in Chapter Two. Finally, inferences and conclusions from the results of each research question are made.

**Primary Research Question One**

The primary research question that examined the causal relationship in this study was, “Does an integrated counselor mindfulness training have an effect on counselor’s feelings of negative countertransference while working with children exhibiting externalized behaviors?” The counselor’s feelings of negative countertransference and positive feelings of challenge were measured by, *Therapist Appraisal Questionnaire* (Cooley & Klingler, 1989; Fauth et al., 1999). The integrated counselor mindfulness training was a one-time, face-to-face, 3-hour training, and weekly independent practice, integrating both mindfulness practices and theoretical tenets of relating to children. To determine a causal effect or relationship between the integrated training on counselors' feelings of negative countertransference and positive feelings of challenge, at least three basic effects need to
occur among the data. This means, through visual analysis, at least three of the four participants’ data need to illustrate a change in slope, level, or a change in both, slope and level across phases and over time, to conclude the integrated counselor mindfulness training has a causal relationship between change in the counselors’ feelings of negative countertransference and positive feelings of challenge.

**Negative countertransference feelings.** Based on the visual analysis conducted on the participants’ scores on the *Therapist appraisal questionnaire* (TAQ; Cooley & Klingler, 1989; Fauth et al., 1999), there was a small basic effect across all four participants. All four participants’ data visually illustrated a small reduction of negative countertransference feelings towards their identified client exhibiting externalized behaviors after completion of the integrated counselor mindfulness training and continued home mindfulness practice. Although all participants illustrated small changes in level and slope between the baseline and the intervention phases, Lauren and Cathy illustrated the biggest level changes among the four participants; while Lauren, Cathy, and Olivia illustrated the biggest change in slope or trend across time. Steven exhibited the smallest level and slope change and Olivia exhibited a small level change as well. Olivia also struggled with engaging in consistent sessions with her client due to client illness and counselor absences; therefore, her overall connection to the data trends was small due to inconsistent data collection. The overall results of this study indicate a small causal relationship between then integrated counselor mindfulness training and the reduction of negative countertransference feelings towards their identified client exhibiting externalized behaviors; in other words, this integrated counselor mindfulness training caused a small reduction in the reduction of negative countertransference feelings towards their identified client exhibiting externalized behaviors. Additionally, through their self-report on
the Post Intervention Follow-Up Questionnaire (Appendix F), the participants reported feeling less critical of their clients, more intentional in session, open, less reactive, and more aware of how their feelings influenced their clients.

The results suggest that all four participants' reduction of negative countertransference feelings occurred due to the participants' completion of an integrated counselor mindfulness training and home practice utilizing both mindfulness and theoretical components. Similar results using both mindfulness practices and theoretical strategies to manage countertransference feelings was also inferred in two previous correlational studies. Robbins & Jolkovski (1987) and Latts & Gelso (1995) conducted correlational studies supporting the notion that counselors with a high awareness of countertransference feelings were less likely to engage in avoidant behaviors or other negative countertransference behaviors. However, Latts & Gelso (1995) also found that counselors who a low understanding of theory but engaged in mindfulness strategies were more successful in managing countertransference than those who did not practice mindfulness but had a high understanding of theory and case conceptualization. However, the counselors who did both, had a high understanding of theory and case conceptualization and engaged in mindfulness practices were the most successful in managing countertransference. The results of this study led to a two-factor model of countertransference management (Latts & Gelso, 1995) suggesting a practice or strategy combining mindfulness practices to increase awareness and theoretical component to enhance understanding and case conceptualization was the strongest countertransference management tool. The current investigation utilized both components and found a small
effect of the integrated counselor mindfulness training on reduction of counselor negative countertransference feelings.

Similarly, this study also supports the findings of Grepmair, Mitterlehner, Rother, & Nickel (2007) and Fatter & Hayes’ (2013) studies as both studies recognized the influence of mindfulness and meditation on reducing anxiety, anger/hostility, obsessiveness, somatization, and psychoticism symptoms (Grepmair, Mitterlehner, Rother, & Nickel, 2007) and countertransference management abilities (Fatter & Hayes, 2013). Although the current investigation did not measure which component of the integrated training was more responsible for the changes in countertransference feelings; all four participants did report that both components of the training were necessary and beneficial.

The present study also had an independent mindfulness practice component that provided mindfulness resources similar to the ones practiced during the training for the participants to engage in weekly throughout the intervention phase. This in-between session or self-care practices supports Arnd-Caddigan’s (2013) findings that engaging in practices outside of session helps to manage countertransference feelings before they engage in countertransference behaviors in session. Arnd-Caddigan’s (2013) study focused on counselor’s engaging in imagined conversations with clients outside of sessions to assist with surfacing unconscious negative countertransference feelings and anxiety that they may be experiencing, which is a different practice than mindful breathing, body scans, and meditations that the present study suggested for the participants to engage in but all of the practices mentioned have similar intentions.
Positive feelings of challenge. Similar to the results for the negative countertransference feelings, the participants’ data illustrated a small basic effect for three of the four participants in enhancing positive feelings of challenge towards the client. Lauren, Cathy, and Olivia illustrated changes in both slope and level over time; while Steven remained fairly stable through his baseline and intervention phases. Cathy and Olivia exhibited the biggest level changes and the most drastic slope changes; while Lauren exhibited the smallest level change and the smallest slope change. Although Steven did not exhibit a change, most of his scores were fairly low and stable throughout the study, so this was not surprising. Again, Olivia struggled with engaging in consistent sessions with her client due to client illness and counselor absences; therefore, her overall connection to the data trends was small due to inconsistent data collection. However, even with inconsistent and lower scores overall, Olivia had the largest level change and drastic slope changes compared to the other participants; illustrating the influence of the training and survey’s sensitivity to change.

The overall results of this study indicated a small intervention effect and a small causal relationship between then integrated counselor mindfulness training and the increased positive feelings of challenge towards their identified client exhibiting externalized behaviors. Additionally, through their self-report on the Post Intervention Follow-Up Questionnaire (Appendix F), all participants except Steven reported seeing positive client change after engaging in the intervention training as evidenced by the clients being more receptive to the counselors, the clients having improved emotional and verbal expression, and shorter periods of regressed behaviors in session. The participants also reported a positive carry
over from the training to their other clients as the training helped them to provide a more intentional and focused session with their clients.

The results suggest that engaging in mindfulness practices and theoretical training to better understand their clients has increased their positive feelings towards their clients, assisted in increasing their level of energy and engagement with their client, and has appeared to influence their client’s prognosis and/or behaviors in session. These results are somewhat similar to Millon and Halewood’s (2015) qualitative study on five psychotherapists experience of regular mindful meditation practices and countertransference experiences in which their participants reported being more present, in the moment, and resulted in experiencing a deeper therapeutic relationship with the client.

Similarly, Peabody and Gelso (1982) examined the impact or influence of empathy as a mediator for countertransference feelings and behaviors in which they found that the greater the empathic ability of the participant/counselor, the more open the counselors were to their countertransference feelings. Although empathy was not directly assessed or used to in the present study, assisting the participants to become more open and aware of their countertransference feelings was a primary focus of the mindfulness components of the integrated training.

**Secondary Research Question One**

The first secondary research question was, “Does an integrated counselor mindfulness training influence the counselor’s ability to manage negative countertransference while working with children exhibiting externalized behaviors as measured by the Countertransference Management Scale (Perez-Rojas, et al., 2017)?”
the participants’ supervisors completed the *Countertransference Management Scale* (CMS; Perez-Rojas, et al., 2017) after each supervision session during the entirety of the investigation. The supervisors only completed the survey that week if they met with their supervisee for clinical supervision.

**Countertransference management.** Although the results of this research question were inconclusive due to low reporting and the supervisors' inability to speak on the topic area of countertransference feelings and behaviors; the results or lack of results bring to light some areas of discussion. First, all four participants reported that they do not often or ever discuss countertransference feelings with their supervisors; therefore, reducing the supervisor's ability to accurately complete the CMS (Perez-Rojas, et al., 2017) but most importantly, reducing the supervisors' ability to assist the participants in identifying, addressing, and managing countertransference feelings or behaviors. Second, the supervisors were instructed to complete the CMS (Perez-Rojas, et al., 2017) after each supervision session with the participants. However, over a course of 14 weeks and weekly emails from the primary researcher, three out of four supervisors engaged in two or fewer supervision sessions in 14 weeks. Third, if supervision is done consistently and openly discusses countertransference behaviors and feelings by both the counselor and supervisor, then supervision itself could act as a management strategy for countertransference.

Although there were inconclusive results on the counselors’ countertransference management abilities; there reduction of negative countertransference feelings, increase in positive feelings of challenge, and self-report of client changes and feeling more present, aware, and engaged in session on the *Post Intervention Follow-Up Questionnaire*
(Appendix F) could imply that the participants were able to manage countertransference feelings and behaviors better than before the training; similar to Baehr’s (2004) findings that counselors who engage in reflection, meditation, and self-care between and after sessions were more likely to control/manage their feelings in session.

However, the participants lack of supervision and lack of open communication with their supervisors is similar to Ligiero and Gelso's (2002) findings that countertransference is inversely related to the strength of the working alliance between supervisors and counselors. More specifically, negative countertransference behaviors were inversely related to both supervision and the therapeutic relationship. The participants in the current study admitted to engaging in negative countertransference behaviors in session with the client; thus, also potentially influencing their relationships with their supervisors.

**Secondary Research Question Two**

The second secondary research question was, “Does an integrated counselor mindfulness training influence the client’s perception of the counseling relationship in session, as measured by the Young Child Session Rating Scale (Duncan et al., 2006)”?

The identified child client working with the participants completed the Young Child Session Rating Scale (Duncan et al., 2006) once a week through the entirety of the study in the attempt to gain feedback from another participant in the counseling relationship other than the counselor and supervisor. However, due to the ages of clients (3-4 years) and/or responsiveness of the child clients, these results were inconclusive as the
indication on the scales were not legible. Therefore, this question was not answered by this investigation.

**Client perception of the counselor.** Although the present study was unable to gain conclusive or viable feedback from the client’s perspective on any noted changes of the counselor and/or the therapeutic relationship after completion of the integrated counselor mindfulness training, the three of the four counselor participants reported on the *Post Intervention Follow-Up Questionnaire* (Appendix F) that they saw changes in their clients’ behaviors and interactions with the counselor as well as changes with other clients on their caseload after engaging in the integrated counselor mindfulness training. The results, although anecdotal, imply similar findings to other research studies indicating that countertransference and improved management of countertransference can influence the clients, the therapeutic relationship, and client outcomes (Gelso, Latts, Gomez, and Fassinger, 2002; Hill, Nutt-Williams, Heaton, Thompson, & Rhodes, 1996; Rosenbaum, Bain, Esterhuizen, & Frost, 2012; Rossberg, Karterud, Pedersen, & Friis, 2007).

**Countertransference behavior.** Although the reduction of countertransference behaviors was not an initial research question, the counselors and supervisors completed the negative countertransference behavior scale within *The Inventory of Countertransference Behavior* (ICB; Friedman & Gelso, 2000) before beginning the study and upon completion of the study. This secondary probe was given in a pre-test/post-test format to see if any changes in negative countertransference behaviors occurred per the counselors and supervisors report. Three of the four participants reported engaging in fewer negative countertransference behaviors after the intervention training.
Additionally, three of the four supervisors also reported noticing reduced negative countertransference behaviors by the counselors in session. In total, the counselors combined reported engaging in 29 negative countertransference behaviors in session prior to the intervention and only 15 negative countertransference behaviors after the intervention training. Some of these behaviors that the counselors engaged in the most before the training were rejecting the client in session, critical of the client in session, the counselor spent time complaining during the session, treated the client in a punitive manner, took an inappropriate advising tone with the client, distanced him/herself from the client, being "absent" during the session, inappropriately questioning the client's motives in session, acted as if he/she was somewhere else in the session, and providing too much structure in session. Upon completion of the study, the counselors reported still engaging, but less often than before, the following behaviors: being "absent" during the session, acting as if he/she was somewhere else during session, some rejecting of the client, taking an inappropriate advising tone with the client, and some distancing him/herself from the client. The results of this survey indicate that there may be a small trend between the integrated counselor mindfulness training and reduced countertransference behaviors but further studies with a larger sample size and more rigor will need to be employed.

The limited results of this survey support previous literature on the various negative countertransference behaviors counselors engage in when they are under stress and/or unaware of the mutual influence of the client/counselor relationship. Fauth and Hayes (2006) investigated the applicability of the transactional theory of stress to the understanding of countertransference triggers in 68 counselors-in-training working with
male clients. The results of the study illustrated that the counselors’ stress appraisals predicted their countertransference behavior. Specifically, therapists' negative appraisals were linked with increased distance/avoidance and hesitance with the client. Additionally, counselors who felt more capable of managing their feelings towards the client tended to avoid him less. In contrast, as the counselors felt more threatened by the client and less able to manage their reactions, hesitance and avoidance increased.

Therefore, enhancing counselor confidence in successfully managing their emotional reactions during the session may also be helpful in reducing their negative transference behaviors (Fauth & Hayes, 2006). Although the results of Fauth & Haye's (2006) study was correlational and there was only a small relationship between the integrated counselor mindfulness training and reduction of the counselors' negative countertransference behaviors noted in the present study, it appears that there may be a connection developing to improved trainings or practices that may be helpful in reducing countertransference behaviors among counselors working with stressful client populations; however, further studies need to be employed.

Many of the studies in countertransference literature focused on understanding the emergence of countertransference (Cutler, 1958), specific populations that tended to trigger countertransference feelings or behaviors (Rossberg, Karterud, Pedersen, & Friss, 2007; Tanzilli, Muzi, Ronningstam, & Lingiardi, 2017), and what some of those negative countertransference interactions looked like in session or by counselors (Abbate, Dunafee, & Fenichel, 1957; Epstein Jr., 2003; Linn-Walton & Pardasani, 2014; Rosenbaum, Bain, Esterhuizen, & Frost, 2012) which was foundational for developing the rationale for the present study. Adding to the previous literature on specific client
populations often triggering countertransference, more specifically negative countertransference interactions, the present study has now added working with children who exhibit externalized behaviors in session to the list of stressful populations to work with acting as potential countertransference triggers. However, this study also adds a possible solution to aiding the counselors’ in managing their negative countertransference feelings and behaviors.

Additionally, previous countertransference research either provides support for the negative influence of countertransference on the therapeutic relationship and client outcomes or possible strategies to manage or reduce countertransference. The majority of the previous countertransference literature has been more exploratory in nature and conducted either through qualitative or correlational examinations, as the studies sought to understand: (a) what kinds of feelings counselors were having towards their clients, (b) the counselors' perceptions of their clients, (c) identifying the relationship between specific client populations and counselors' countertransference engagement, (d) the impact of countertransference on the therapeutic relationship, (e) and the potential management strategies for managing countertransference. However, the present study is similar to the previous themes of examination but also differs as a rigorous, experimental research design was utilized to examine the effects of an integrated counselor mindfulness training on counselors' negative countertransference feelings, management abilities, and behaviors towards clients exhibiting externalized behaviors.

Overall, the results of the present study suggest that the integrated counselor mindfulness training incorporating mindfulness practices, theoretical tenets of relating to children, and independent mindfulness practices had a small impact on reducing the
counselors' feelings of negative countertransference and increasing their positive feelings of challenge. In addition, the results of this study suggest that there may be a small relationship between the counselors' abilities to manage their countertransference better after receiving the training than before. Also, although not significant, there may be a connection between a reduction in countertransference behaviors and engaging in an integrated counselor mindfulness training. Lastly, although anecdotally, it appears that the counselors feel that they integrated counselor mindfulness training also may have influenced their presence in session; thus, influencing their clients’ behaviors and prognosis.

Social Validity

The Post Intervention Follow-Up Questionnaire (Appendix F) collected data reflective of the participants’ thoughts, feelings, and recommendations of the investigation and integrated counselor mindfulness training. According to the participants, all four participants reported that they: (a) liked the intervention very much (highest ranking), (b) would engage in the intervention training again, (c) would recommend the intervention training to other professionals, (d) were interested in learning more about the topics covered in the training, and (e) saw positive carry over from the training to their other clients as the training helped provide a more intentional and focused session with their clients. All participants reported that the 3-hour time frame was sufficient and "just right" and all the topic areas covered were necessary and fit well together. However, one participant did mention the benefit of adding booster sessions throughout the study to complement the skills learned in the training. Additionally, three participants reported seeing positive client change in the identified client as well as other
clients on their caseloads after engaging in the intervention training as evidenced by the clients being more receptive to the counselors, the clients having improved emotional and verbal expression, and shorter periods of regressed behaviors in session; while one counselor did not report noticing any changes in the identified client. Also, the participants reported feeling less critical of their clients, more intentional in session, open, less reactive, and more aware of how their feelings influenced their clients. Lastly, all participants engaged in regular, independent mindfulness practice as evidenced by their daily mindfulness logs at least 3 times per week. The most used mindfulness practice that was often used multiple times per day and throughout the week was the mindful minute exercise with the body scan recording as the second most used practice.

**Limitations**

As all research studies have its limitations, this study was no different. First, although single case research is a rigorous experimental design with consistent and repetitive measurement, single case research, specifically the multiple probe design, has its own challenges and limitations. The following are some limitations of SCRD: (a) the amount of time participants are in baseline, participants must remain in baseline for an extended period of time without receiving the intervention which can lead to testing fatigue and lack of motivation to continue to the intervention phases; (b) testing effects, the participants are continuously measured and evaluated, therefore, testing fatigue or other testing affects can occur; (c) visual analysis, although there are specific components and structure to visual analysis, it can be subjective; lastly, (d) reactivity or lack of reactivity as in this investigation, meaning that typically there is an element of strict control for SCRD conducted within a laboratory setting which increases uncertainty in
knowing if the intervention will be helpful outside of the controlled experimental environment or population. However, this investigation occurred in a naturalistic setting which strengthens the argument that the intervention training can work with practicing counselors; but there was less control than if this investigation was conducted in a laboratory setting; thus, utilizing a naturalistic setting with limited control is a strength and a limitation.

Another limitation of this study focuses on data collection or the instruments used to collect data. Typically, SCRD utilizes direct observation of overt behaviors for a more objective and concrete form of data collection. However, since this study measured internal mechanisms within the participants’ and their clients (i.e. counselors and client feelings, management abilities, and self-reported behaviors) direct observation could not be used; thus, surveys and questionnaires were used to measure the constructs under investigation. Not all of the questionnaires are normed for continuous use on the same individual due to the limited questionnaires measuring countertransference and limited questionnaires in counseling literature that are normed for consistent use on the same individual after every session. Additionally, although most of the surveys and questionnaires used for data collection reported strong reliability and validity psychometrics; *The Inventory of Countertransference Behavior* (ICB; Friedman & Gelso, 2000), *Therapist Appraisal Questionnaire* (TAQ; Cooley & Klingler, 1989; Fauth et al., 1999), and *Countertransference Management Scale* (CMS; Perez-Rojas et al., 2017), there was one survey with no psychometric properties; *Young Child session rating scale* (YCSRS; Duncan et al., 2006) and two other researcher-created questionnaires; *Daily Mindfulness Activity Log* (Appendix E) and the *Post-Intervention Follow-Up Questionnaire*
(Appendix F). Even with strong psychometrics, all the surveys were self-report which increases subjectivity, the likelihood for bias, and potential social desirability. Additionally, the participants’ scores on the *Therapist Appraisal Questionnaire* (TAQ; Cooley & Klingler, 1989; Fauth et al., 1999) were fairly low throughout the study in both baseline and intervention phases; therefore, the magnitude of change was low. Also, the *The Inventory of Countertransference Behavior* (ICB; Friedman & Gelso, 2000) was used for inclusion criteria to ensure that the behaviors the counselors were engaging in were, in fact, countertransference behaviors; however, the TAQ (Cooley & Klingler, 1989; Fauth et al., 1999) was not used as the part of inclusion criteria; however, by using the TAQ as part of the inclusion criteria could have assisted in selecting participants with higher and similar ranges of scores to aid in a potentially higher magnitude of change.

A final limitation, still regarding the instrumentation and data collection, was the lack of available feedback from the clients and the supervisors. Although an attempt was made to collect information from multiple perspectives, based on the child clients’ ages and developmental levels, data could have been collected in a more developmentally appropriate way by addressing their parents and/or utilizing some form of direct observation. As for the supervisors, although the lack of available information due to few supervision sessions and lack of openness between the supervisor and supervisee regarding countertransference is a limitation, it was also an interesting finding that has possible implications for the role of supervision in its relationship with countertransference.
Implications

The purpose of this study was to investigate the effect of an integrated counselor mindfulness training on negative countertransference for counselors working with children exhibiting externalized behaviors. Specifically, the integrated counselor mindfulness training utilized in this study included; (a) mindfulness training and practice (Kabat-Zinn, 2013) and (b) education on the theoretical tenets of relating to children (Landreth, 2012). The results of this study provide empirical support for an integrated counselor training in reducing negative countertransference feelings and increasing positive feelings of challenge towards clients exhibiting externalized behaviors in session. Additionally, counselors engaged in the integrated counselor mindfulness training also reported engaging in fewer negative countertransference behaviors and reported to notice positive client change. Implications for counselor training and preparation, clinical and supervision practice, mindfulness and theoretical integration, and single case research designs and counseling research is outlined below.

Counselor Preparation

The person of the counselor is regarded as an important element of counselor development and the counseling profession as the counselors'-in-training or counselors' dispositional qualities, personal characteristics, and the past experiences all influence the counseling relationship and the therapeutic process (Norcross, 2011; Rogers, 1957). Therefore, understanding the counselors'-in-training thoughts processes, feelings, and/or levels of countertransference towards a client or a particular client population is an important topic to address during counselor preparation. As mentioned throughout chapter two and earlier in the present chapter, there is empirical support noting the
negative influences of unmanaged countertransference to the counseling relationship and client outcomes (Gelso, & Hummel, 2011; Strupp, 1980) as well as the improved counselor-client interactions and therapeutic progress when the counselor is aware of countertransference feelings and is used to better understand oneself and the client (Gelso & Hayes, 2007; Racker, 1957). Therefore, incorporating a form of countertransference management skills into coursework would be invaluable to the development of counselors-in-training.

To best manage countertransference, Counselor Educators could begin to incorporate open discussions about the inevitability of experiencing countertransference towards clients in their future work. These conversations allow counselors-in-training to acknowledge and discuss countertransference freely and learn ways to manage those feelings and experiences before entering the counseling field. Additionally, incorporating mindfulness practices, enhanced conceptualization skills, and open conversations about countertransference; counselor educators can model the acceptance and understanding of countertransference experiences; thus, increasing counselors-in-training self-awareness and self-integration. Further developing counselors’-in-training abilities to acknowledge, address, and manage their countertransference feelings before it manifests into their sessions, reduces the negative influence on clients and can provide insight for better client treatment.

In addition to incorporating more mindfulness practices, although child and adolescent counseling or something similar is often a class offered in most counselor education programs as an elective, it is recommended that this course or tenets of relating and working with children become an area that is studied further in counselor
preparation. Regardless of counselor preparation tracks or desire to work with specific populations, children are one of the highest groups needing and referred for counseling as 1 in 6 children aged 2–8 years in the United States has a diagnosed mental, behavioral, or developmental disorder (Cree et al., 2018). In addition to the high need for working with children, the way in which children communicate, interact with the world, and process life events are very different from adults (Landreth, 2012). Often, due to development differences and lack of understanding, children are a population that is difficult and stressful to work with; thus, creating tension and potential countertransference experiences within counselors (Guest et al., In review). Therefore, increasing exposure to this topic area and increasing counselors’-in-training knowledge base of these developmental differences and ways to interact with children, counselors can provide better treatment to children with less stress and with more confidence.

**Clinical and Supervision Practice**

Clinically, the results of this study and previous literature on this topic, suggest that counselors who are able to manage their countertransference feelings can use countertransference to enhance client insight and provide better client care (Gelso, Latts, Gomez, and Fassinger, 2002). Additionally, the results of this study also support previous literature that suggests that combining mindfulness practices with theoretical support enriching case conceptualization skills is effective in managing countertransference feelings and behaviors (Hayes, Gelso, and Hummel, 2011; Latts & Gelso, 1995; Robbins & Jolkovski, 1987). Therefore, practicing counselors and counselors-in-training are encouraged to engage in a regular regimen of mindfulness practices, reflection, and
further study in theoretical aspects of their work with particular populations to provide the best client care possible.

In addition to clinical applications between the counselor and client, there are also supervision implications from this study informing potential supervision practices. Clinical supervision is not only mandated by CACREP standards (CACREP, 2016) and state licensure requirements, but supervision also acts as a gatekeeping function for the profession and provides guidance and support while new counselors are still developing and learning. However, if clinical supervision is not provided with openness and trust between the counselors and supervisors, then the effect of supervision is weakened. The present study highlighted an area of importance within supervision as the participants in the study reported that they did not discuss their experiences of countertransference or their negative feelings towards their clients with their supervisors; nor did the supervisors’ assessment of their participants’ countertransference behaviors in session match the reports made by the participants themselves regarding their own work with clients. Additionally, one participant mentioned a desire to add booster-type sessions to the integrated counselor mindfulness training to act as intermittent check-ins or touch-ups for further processing of countertransference experiences and more information regarding working with children; which is similar to what supervision could/should provide. Therefore, including elements from the integrated counselor mindfulness training in supervision processes could reduce countertransference experiences among counselors and in turn benefit client progress.
Managing Countertransference

Understanding and accepting that countertransference is inevitable (Gelso and Hayes, 2007) is a key component to raising awareness of countertransference experiences. Awareness of countertransference feelings, triggers, and behaviors is of the utmost importance as unchecked countertransference can harm the therapeutic relationship and client progress (Gelso, & Hummel, 2011; Strupp, 1980). However, awareness of countertransference is just the first step in managing the negative effects of countertransference and using those experiences in a positive way. Increased self-awareness, self-integration, self-regulation, self-reflection, curiosity about the client, and increased understanding of the particular client all are necessary to best manage countertransference. Mindfulness practices are known to enhance self-awareness, self-integration, self-regulation, self-reflection (Gelso, Latts, Gomez, and Fassinger (2002; Kabat-Zinn, 2013; Shapiro, 1992) and specific education or continued educational training on particular client populations (i.e. age groups, diagnoses, etc…) help to increase curiosity and facilitate deeper understanding about that particular client group, and improve case conceptualization skills. Therefore, engaging in an integrated counselor mindfulness training that utilizes mindfulness practices and specific theoretical tenets related to a specific client population is encouraged to best manage countertransference experiences among helping professionals.

Single Case Research Designs and Counseling Research

Over the last few years, there has been an increased interest in utilizing single case research designs (SCRD) within counseling research. For example, a flagship journal for the counseling profession, the Journal of Counseling and Development (JCD),
has recently put out calls for more single case research to be done and published in our field. As mentioned earlier, SCRD is often used when testing the effectiveness of an intervention, if the population of interest is small or specialized where it may be difficult to find large numbers of participants meeting that criteria, and/or if the intervention of interest is novel (Kazdin, 2011). Utilizing single case research to investigate constructs within the counseling field appears to be an easy fit as single case research is a rigorous, experimental design, that allows for causal inferences, and is completed with one or very few participants which aligns perfectly with the small, specific populations the counseling profession works with regularly. However, due to its rigor and ability to infer causality with few participants, single case research methodology is very specific, intentional, and structured in ways that cannot be manipulated without eliminating the significance of any and all results and are outlined within the *What Works Clearinghouse* (Kratochwill et al., 2010).

Due to an increasing focus within counseling research in using single case research designs for causal investigations; the counseling profession is still learning how to appropriately use the design to investigate constructs among the counseling profession. Although this is not an extensive list; there are a few key components that are imperative for valid results that the counseling profession needs to pay strict adherence to when using SCRD. First, single case research is typically used in educational research to measure overt behaviors; however, many counseling constructs are not behavioral or overt but are more internal processes. This is not an issue but requires counseling researchers to either incorporate even clearer operational definitions of the constructs measured through observation or use participant completed surveys and questionnaires to
measure constructs that are not observable (i.e. internal feelings, thoughts, or triggers). Without finite and clear operational definitions of a particular construct, measurement of the observable construct will not be accurate or valid.

Second, a vital indicator of influence or effect of an intervention is measured change across time, across participants, settings, or interventions across both the baseline and intervention phases depending on the structure of the SCRD (Kazdin, 2011; Kratochwill et al., 2010). For example, the present study utilized a SCRD across participants meaning that in order for a causal relationship to be determined there needed to be at least three basic effects (i.e. significant changes) in the data between the baseline and interventions phases over time and across three participants to infer causation. However, there are two other contingencies to this element. The baseline phases need to be stable before the participant enters the intervention phase and intervention phases also need to be staggered (Kazdin, 2011). In the most basic sense a stable baseline means a stable pattern of at least three to five data points indicate a positive, negative, or flat trend is apparent (Kratochwill et al., 2010), Staggered intervention phases across participants means that all participants enter into the intervention phase at different times and only after the participant before them displays an intervention effect. The baseline stability and staggered participant entrance to the intervention phase is paramount for reducing threats to validity and indicating an effect of the intervention. Without it, there is limited to no validity of results as the change in behavior could have occurred due to extraneous variables.

Finally, data analysis in single case research does not rely on statistical measurement but visual analysis to infer causation. Although there are some statistical
measures used in single case research such as the Tau-U, points exceeding the mean (PEM), and the percent of nonoverlapping data (PND), these measures only account for data overlap which is just one area of analysis for SCRD. Visual analysis includes: (a) data overlap, (b) data trend/slope, (c) level, (d) variability, (e) consistency of patterns across similar phases, (f) immediacy of effect, and (g) vertical analysis (Kratochwill et al., 2010). Visual analysis provides a closeness to the data allowing for researchers to identify individual as well as group change across participants (Kazdin, 2011). Additionally, visual analysis allows researchers to identify trends or changes in the data that may have occurred due to extraneous variables and not the intervention which the statistical analyses lack. For example, only relying on the Tau-U, PEM, and the PND statistical measures, that only evaluate overlap, to infer a causal relationship between positive participant change and the intervention; the researcher may miss that a participant was already trending in a positive direction during the baseline phase and continued trending in a positive direction during the intervention phases, illustrating that the intervention did not change the participant behavior and the behavior improved on its own over time. However, since the data points did not overlap, the statistical measures would report a low rate of overlap; thus, misleading the researcher to making a false causal inference regarding the effects of the intervention. All elements of visual analysis are important and required in inferring causation among the data. Although visual analysis may be deemed subjective, What Works Clearinghouse (Kratochwill et al., 2010) provides a full technical document explaining each variable and how and what to assess.

As the use of single case research designs continues to grow and become more popular among the counselor profession, strict adherence to the SCRD guidelines is of the utmost importance as variance will be detrimental to the studies' results. Counseling
researchers are encouraged to utilize the SCRD methodology outlined in the *What Works Clearinghouse* (Kratochwill et al., 2010) as guidelines when conducting SCRD. Data and research inform clinical treatments, funding, and grow professional identification and integrity; therefore, the research designs and methodologies used to determine results need to be conducted with fidelity.

The present study sought to demonstrate appropriate and proper use of a multiple probe, single case research design, across participants, using valid reliable surveys and questionnaires to measure internal processes found within the counseling profession. Through thorough visual analysis processes, the present study inferred a small causal relationship between an integrated counselor mindfulness training and countertransference feelings.

**Future Research**

The results of this study indicate that an integrated counselor mindfulness training, combining mindfulness and theoretical tenets of relating to children, can reduce negative countertransference feelings and increase positive feelings of challenge in counselors working with children exhibiting externalized behaviors. Additionally, the results suggest that they also may be a relationship between an integrated counselor mindfulness training and improved countertransference management abilities and reduced countertransference behaviors in counselors working with children exhibiting externalized behaviors; however, this needs to be further studied with a larger sample to support these results. Additionally, the integrated counselor mindfulness training was created by the primary researcher and was influenced by elements of Kabat-Zinn's (2013) Mindfulness-Based Stress Reduction, Shapiro et al.'s (2006) *Intention, Attention, Attitude*
Model, Thera's (1954) meditation practices, and Landreth's (2012) theoretical tenets of relating to children. Therefore, replication of this SCRD study used with the same population as well as counselors working with other high-stress populations is welcomed and needed.

Although this study utilized surveys and questionnaires for data collection instead of observation which is permitted but not often used as it requires for the surveys and questionnaires to be normed for continuous use on the same individuals. Not all of the questionnaires for this study were normed for continuous use on the same individual due to the limited questionnaires measuring countertransference and limited questionnaires in counseling literature that are normed for consistent use on the same individual after every session. Therefore, future research could focus on norming the current CT measurements and other common surveys and questionnaires used in the counseling field on continuous and repetitive use so they can be more reliably used in SCRD. In addition, future studies may look to identify more overt ways to operationalize CT and other counseling constructs so that direct observation can be used to measure these constructs more fully and behaviorally.

Another area for future research includes conducting more counseling research, especially research focused on countertransference, in more naturalistic settings. There is a dearth of countertransference research and counseling research in general that utilizes naturalistic settings as most of it is conducted in laboratory settings and with students. Future research can focus on involving professional counselors in the field and not just students in a controlled environment. Lastly, the integrated counselor mindfulness training in the present study appeared to positively influence practicing counselors via a
one-time, 3-hour training with continued independent practice. However, through the study, a participant recommended booster sessions or intermittent check-ins with the implementer and the researcher noted a lack of supervision and/or openness between the supervisors and counselors. Therefore, future research could include integrating the current counselor training into supervision or creating a supervision intervention that includes elements of the integrated counselor mindfulness training to measure its effects on counselor countertransference experiences.

This study attempted to measure the influence of an integrated counselor mindfulness training on the counselors’ ability to manage negative countertransference; however, there was not enough data present to determine the influence. Nevertheless, there appeared to be a trend between engaging in the integrated counselor mindfulness training and improved countertransference abilities per the supervisor and counselor’s reports. Therefore, future research could examine this trend further through a larger correlational study or through a SCRD investigation of, this, or a similar training and counselors’ countertransference management abilities. Lastly, it would be interesting to examine the influence of countertransference management strategies, mindfulness, and child and adolescent coursework in counselor education programs on counselor efficacy in working with this population in internship or practicum and counselor burnout for licensed practicing counselors.

Conclusion

The present study is the first study to utilize a multiple probe, single case research design to study the effects of an integrated counselor mindfulness training on counselors' countertransference feelings. Additionally, the present study is the first experimental,
intervention study integrating mindfulness practices and theoretical tenets to reduce and/or manage counselor countertransference experiences. The results of this study illustrated a small effect of the integrated counselor mindfulness training on the reduction of counselors' negative countertransference feelings and a small effect on increasing the counselors' positive feelings of challenge among counselors working with children exhibiting externalized behaviors in session. Lastly, the results of this study suggest that the integrated counselor mindfulness training may have an influence on counselors' countertransference management abilities and behaviors but will need further examination and future studies to identify the validity and/or strength of this relationship. While this study does have its limitations, the results provide empirical support for using an integrated mindfulness practices and theoretical tenets to assist with counselors' countertransference feelings among counselors working with children exhibiting externalized behaviors.
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http://dx.doi.org/10.1176/appi.ajp.162.5.890


[http://dx.doi.org/10.1037/h0089436](http://dx.doi.org/10.1037/h0089436)


APPENDIX A

IRB APPROVAL LETTER

Jessie Dawson
College of Education
Department of Counselor Education
Wardlaw 258
Columbia, SC 29208

Re: Pro00082789

Dear Ms. Jessie Dawson:

This is to certify that the following proposal entitled, Managing Negative Countertransference Utilizing an Integrative Counselor Mindfulness Training for Counselors Working with Children Exhibiting Externalized Behaviors, was reviewed and approved by the University of South Carolina Institutional Review Board (USC IRB) on 10/5/2018 by Expedited review (category 6 and 7). Approval is for a one-year period from 10/5/2018 to 10/4/2019. The Principal Investigator must submit a Continuing Review and required attachments to request continuing approval or closure. IRB approval for the study will expire if continuing review approval is not granted before 10/4/2019.

When applicable, approved consent/assent documents are located under the “Stamped ICF” tab on the Study Workspace in eIRB.

PRINCIPAL INVESTIGATORS ARE TO ADHERE TO THE FOLLOWING APPROVAL CONDITIONS

• The research must be conducted according to the proposal/protocol that was approved by the USC IRB
• Changes to the procedures, recruitment materials, or consent documents, must be approved by the USC IRB prior to implementation
• If applicable, each subject should receive a copy of the approved date stamped consent document
• It is the responsibility of the principal investigator to report promptly to the USC IRB the following:
  o Unanticipated problems and/or unexpected risks to subjects
  o Adverse events effecting the rights or welfare of any human subject participating in the research study
• Research records, including signed consent documents, must be retained for at least (3) three years after the termination of the last IRB approval.
• No subjects may be involved in any research study procedure prior to the IRB approval date, or after the expiration date.
• At the time of study closure, a Continuing Review form is to be used for the final report to the USC IRB.

The Office of Research Compliance is an administrative office that supports the University of South Carolina Institutional Review Board. If you have questions, Lisa Johnson at lisaj@mailbox.sc.edu or (803) 777-6670.

Sincerely,

Lisa M. Johnson
ORC Assistant Director and IRB Manager
APPENDIX B

INFORMED CONSENT – COUNSELOR PARTICIPANTS

UNIVERSITY OF SOUTH CAROLINA

CONSENT TO BE A RESEARCH SUBJECT (Counselor Participants)

Managing Negative Countertransference and Feelings of Dislike Utilizing an Integrated Counselor Mindfulness Training for Counselors Working with Children Exhibiting Externalized Behaviors

PURPOSE AND BACKGROUND:
You are being asked to volunteer for a research study conducted by Jessie D. Guest, MA/Ed.S, LPC, NCC, RPT, QS. I am a Doctoral Candidate in Counselor Education & Supervision program within the Department of Educational Studies at the University of South Carolina. The University of South Carolina, Department of Educational Studies is sponsoring this research study. The purpose of this study is to measure the effects of an integrated mindfulness training on negative countertransference and therapeutic alliance for counselors working with children exhibiting externalized behaviors. The inclusion criteria to participate in this study are as follows:

1. Participants is a licensed Mental Health Counselor in the State of North or South Carolina (LPC or LPC/A)
2. Participant has 1-5 years of field experience as a counselor.
3. Participant works with children, ages 3-9, that exhibit externalized behaviors in session (i.e. hitting, kicking, screaming, throwing/breaking things, etc.).
4. Participant’s supervisor reports that the participant is experiencing negative countertransference behaviors (as measured by The Inventory of Countertransference Behavior (ICB; Friedman & Gelso, 2000).
5. Participant does not have prior experience or training in mindfulness practices.

You are being asked to participate in this study because you currently meet the inclusion criteria for this study.

This study is being conducted at your counseling office or agency and will involve a primary researcher and 14 volunteers (four counselors, four supervisors, 2 volunteers for treatment fidelity, and 4 clients). This form explains what you will be asked to do, if you
decide to participate in this study. Please read it carefully and feel free to ask questions before you decide about participating.

**PROCEDURES:**
If you agree to be in this study, the following will happen:

1. You will be asked to complete a general demographic survey.
2. You will select three clients in your current case load, ages 3-9, that you identify as exhibiting externalized behaviors in session and acknowledge having negative feelings towards.
3. You will provide your regularly weekly individual counseling sessions to each of the three clients through the duration of this study. Each individual session will last approximately 45-minutes.
4. You will complete the *Therapist appraisal questionnaire* (TAQ; Cooley & Klingler, 1989; Fauth et al., 1999) after each session or as instructed by the researcher.
5. During the intervention, you will participate in one 3-hour integrated, mindfulness training, facilitated by the lead researcher.
6. During the intervention, you will engage in weekly mindfulness activities outside of the in-person mindfulness sessions and record your practice and reflections on the provided independent practice logs.
7. You will continue to offer weekly individual counseling services to you clients until the conclusion of this study.

**DURATION:**
Participation in the study may take 10 or more weeks.

**RISKS:**
There are no unique or foreseeable risks associated with participation in this study.
BENEFITS:
Counselor participants may benefit by engaging in mindfulness skill development and enhanced child client conceptualization skills through participation in the integrated mindfulness training. Client and counselor therapeutic rapport may increase as well.

COSTS:
There will be no costs to you for participating in this study other than time spent during the intervention and independent practices.

PAYMENT TO PARTICIPANTS:
In return for your time and effort, you will receive the following:

1. A $125 VISA gift card or cash payment.

CONFIDENTIALITY OF RECORDS:
Sensitive and personal information may be disclosed during the course of individual counseling sessions. In accordance with the American Counseling Association’s Code of Ethics (2014) and Health Insurance Portability and Accountability Act (HIPPA), all confidentiality of client information will be maintained according to your agency’s policies and procedures.

Study information and recordings will be securely stored in locked files and on password-protected computers/electronics storage devices. All video recordings will be deleted at the conclusion of this study. Results of this research study may be published or presented at seminars; however, the report(s) or presentation(s) will not include your name or other identifying information about you.

VOLUNTARY PARTICIPATION:
Participation in this research study is voluntary. You are free not to participate, or to stop participating at any time, for any reason without negative consequences. In the event that you do withdraw from this study, the information you have already provided will be kept in a confidential manner. If you wish to withdraw from the study, please call or email the principal investigator listed on this form.

PARTICIPANT AGREEMENT:
I have been given a chance to ask questions about this research study. These questions have been answered to my satisfaction. If I have any more questions about my participation in this study I am to contact Jessie D. Guest, MA/Ed.S, LPC, NCC, RPT, QS at jessied@email.sc.edu.

Questions about your rights as a research subject are to be directed to, Lisa Johnson, Assistant Director, Office of Research Compliance, University of South Carolina, 1600 Hampton Street, Suite 414D, Columbia, SC 29208, phone: (803) 777-7095 or email: LisaJ@mailbox.sc.edu.
I agree to participate in this study. I have been given a copy of this form for my own records. If you wish to participate, please sign below.

Signature of Subject / Participant ____________________ Date __________

Printed Name of Subject / Participant ____________________ Date __________

Signature of Qualified Person Obtaining Consent ______________ Date __________
APPENDIX C

GENERAL DEMOGRAPHIC SURVEY – COUNSELORS

General Demographics Survey (Counselor-Participants)

Directions: Please complete the following general demographics survey. All responses are confidential.

Please list your personalized individual identifier provided to you by the primary researcher _________

Gender: ___Cisgender Male ___Cisgender Female ___Transgender Woman ___Transgender Man ___Other

Sexual Orientation: ___Heterosexual ___Gay ___Lesbian ___Bisexual ___Not Listed (Please specify)_____________.

Age: _____

Ethnicity: ___African-American ___Asian-American ___Caucasian/White (Non-Hispanic) ___Hispanic ___Native-American ___Pacific/Islander ___Other

EDUCATION:

Highest Degree Completed: ___ High School ___Associate ___Bachelor ___Masters ___Specialist ___Doctoral

What degree(s) do you currently hold? __________________

What university/college will you complete your current academic training at?
College/University: __________________________________________________

Expected Graduation Year: ______________

Number of years as an LPC or LPC-A? ______________

Current Theoretical Orientation: _________________________________________
MINDFULNESS:
Do you currently practice mindfulness and/or meditation? ____Yes____No

CLIENT INFORMATION:

Client’s Ethnicity: ___African-American ___Asian-American ___Caucasian/White (Non-Hispanic) ___Hispanic ___Native-American ___Pacific/Islander ___Other

What is the clinical diagnosis(es) of the child client you selected for this study?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What is the current age (in years) of the selected child client?
____________________________

Please describe the kind of externalized behaviors that the selected child client exhibits during session.
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

How many months have you worked with this particular population?
____________________________

To your knowledge, how many months has the selected child client received therapeutic services from your agency?
________________________________________________________________________

How many weeks have you provided therapeutic services to the selected child client?
________

Who is able to speak to your feelings towards the selected child client the best and with most accuracy?
________________________________________________________________________

Please provide the name and email address of the colleague or supervisor that is able to speak to your feelings towards the selected child client.
________________________________________________________________________
APPENDIX D

GENERAL DEMOGRAPHIC SURVEY – SUPERVISORS

General Demographics Survey (Supervisor-Participants)

Directions: Please complete the following general demographics survey. All responses are confidential.

Gender: ___ Cisgender Male ___ Cisgender Female ___ Transgender Woman ___ Transgender Man ___ Other

Age: ___

Ethnicity: ___ African-American ___ Asian-American ___ Caucasian/White (Non-Hispanic) ___ Hispanic ___ Native-American ___ Pacific/Islander ___ Other

EDUCATION:

Highest Degree Completed: ___ High School ___ Associate ___ Bachelor ___ Masters ___ Specialist ___ Doctoral

What degree(s) do you currently hold?

__________________________________________________________________________________

What university/college will you complete your current academic training at?

College/University: _________________________________________________________________

Expected Graduation Year: ____________

How long have you been a supervisor? ____________

Current Theoretical Orientation: _______________________________________________

Have you had any formal mindfulness or MBSR training or certification? ____________________________
Are you the participant's supervisor or colleague?

______________________________

How many years have you worked with the participant?

______________________________
**APPENDIX E**

DAILY MINDFULNESS ACTIVITY LOG

Counselor’s Identifier: __________

Directions:
Please engage in one or more mindfulness practices learned during the Integrative Mindfulness Practice each day. Participants should engage in at least 20-35 minutes of mindfulness practice per day. Upon completion of the practices, please complete the chart below. Practice logs will be collected by the researcher at the end of each week.

**How likely are you to complete at least one daily mindfulness practice? ________

1- Not at all likely 2- Somewhat likely 3- Likely 4- Moderately likely 5- Very likely

<table>
<thead>
<tr>
<th>Day/Date</th>
<th>Please select the mindfulness practice(s) you engaged in:</th>
<th>Duration of Mindfulness Practice</th>
<th>Awareness of: (thoughts, feelings, body sensations)</th>
<th>Reflection (Insights gained through practice, Ideas or thoughts for further exploration)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>Guided Meditation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Music Meditation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Body Scan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1-Minute Meditation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diaphragmatic Breathing Practice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuesday</td>
<td>Guided Meditation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Music Meditation</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Body Scan</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>1-Minute Meditation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diaphragmatic Breathing Practice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wednesday</td>
<td>Guided Meditation</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Music Meditation</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Body Scan</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>1-Minute Meditation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diaphragmatic Breathing Practice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thursday</td>
<td>Guided Meditation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td>Monday</td>
<td>Tuesday</td>
<td>Wednesday</td>
<td></td>
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<td>-----------</td>
<td>--------</td>
<td>---------</td>
<td>-----------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Music Meditation</td>
<td>Body Scan</td>
<td>1-Minute Meditation</td>
<td>Diaphragmatic Breathing Practice</td>
</tr>
<tr>
<td>Friday</td>
<td>Guided Meditation</td>
<td>Music Meditation</td>
<td>Body Scan</td>
<td>1-Minute Meditation</td>
</tr>
<tr>
<td>Saturday</td>
<td>Guided Meditation</td>
<td>Music Meditation</td>
<td>Body Scan</td>
<td>1-Minute Meditation</td>
</tr>
<tr>
<td>Sunday</td>
<td>Guided Meditation</td>
<td>Music Meditation</td>
<td>Body Scan</td>
<td>1-Minute Meditation</td>
</tr>
</tbody>
</table>
APPENDIX F

POST-INTERVENTION FOLLOW-UP QUESTIONNAIRE

Post-Intervention Follow-Up Questionnaire

When answering the below questions, please consider your participation in the following study: “Managing Negative Countertransference and Feelings of Dislike Utilizing an Integrated Counselor Mindfulness Training for Counselors Working with Children Exhibiting Externalized Behaviors.”

1 (not at all) - 2 (somewhat) - 3 (very much)

As a whole, how much did you like the intervention? ______

1. Was the content of the intervention helpful in improving your work with children expressing externalized behaviors? ______

2. Was this intervention helpful in your work with other clients? ______. Please explain______________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

3. Did you notice any changes in your client’s behaviors or progress after completing the training? Yes or No

If yes, please explain:______________________________________________________

________________________________________________________________________
1(not likely) - 2(somewhat likely) - 3(very likely)

4. What is the likelihood that you will use the mindfulness skills and knowledge acquired from participating in this intervention in the future? ______________

5. What is the likelihood that you will seek out additional information or trainings related to mindfulness or work with children? ______________

Please answer to the following to the best of your ability?

6. Which element of the training, mindfulness or theory relating to children, was most helpful or were they both equally helpful? ______________

7. Would you participate in the intervention again? Yes or No __________

8. Would you recommend this intervention to others? Yes or No __________

9. Do you feel the integrated training 3-hour timeframe was sufficient, not enough, or too much time for learning and utilizing the skills taught? ______________

Below please provide any recommendations or additional thoughts/opinions related to the training or your participation in the study:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
### APPENDIX G

**TREATMENT FIDELITY CHECKLIST**

<table>
<thead>
<tr>
<th>Completed</th>
<th>Event</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>PART ONE</strong></td>
</tr>
</tbody>
</table>
|            | Introduction & Welcome | • Discussion of *why* managing Negative Countertransference is important  
|            |       | - Hayes, Gelso, & Hummel (2011)  
|            |       | - Linn-Walton & Pardasani (2014)  
|            |       | - Robbins & Jolkovski (1987)  
|            |       | - Latts & Gelso (1995)  
|            |       | • Explanation of what is ahead:  
|            |       | - Information on stress response systems  
| Completed  |       | - Mindfulness breathing, meditation, and body scan practices  
|            |       | - Theoretical tenets of relating to child clients  
|            |       | • Definitions of Mindfulness (*Kabat-Zinn, 1990, Thera, 1954; Bishop et al., 2004*)  
<p>| Not Completed |       |                   |
| Completed  |       |                   |
| Not Completed |   |                   |</p>
<table>
<thead>
<tr>
<th>Completed</th>
<th>Not Completed</th>
<th><strong>PART TWO</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Opening Practice</td>
<td>• Diaphragmatic Breathing Practice (<em>MBSR curriculum; Kabat-Zinn, 2013</em>)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Reflection on what that exercise was like for participants</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discussion of IAA Model</td>
<td>• Discussion of IAA Model (Intention, Attention, and Attitude Model) (<em>Shapiro et al., 2006</em>)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Understanding Stress</td>
<td>• Stress- defined (<em>Lazarus and Folkman, 1984</em>)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(MBSR curriculum; Kabat-Zinn, 2013)</td>
<td>• Responding to Stress instead of Reacting to Stress</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Explanation of R.A.I.N</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• <strong>R.A.I.N. (Tara Brach)</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• <strong>Recognize</strong> there is stress.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• <strong>Allow</strong> for feelings to be expressed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• <strong>Investigate</strong> what is the worst part, why are they/I engaging in these behaviors. What are they trying to say?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• <strong>Nurture</strong> with compassion.</td>
</tr>
<tr>
<td></td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td><strong>PART THREE</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Breathing exercise and Processing</td>
<td>• Mindful Minute Exercise</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Provides space and time for the participants to ask questions and process the breathing practice.</td>
</tr>
<tr>
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</tr>
<tr>
<td></td>
<td></td>
<td>Pairing Exercise and Processing</td>
<td><strong>30</strong> Have the participant think about a negative thought or feeling he/she has about a particular client and use diaphragmatic breathing to reduce emotional reactivity.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>31</strong> Provides space and time for the participants to ask questions and process the breathing practice.</td>
</tr>
<tr>
<td>Completed</td>
<td>Not Completed</td>
<td>Body Scan and Processing</td>
<td>Completed</td>
</tr>
<tr>
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</tr>
<tr>
<td></td>
<td></td>
<td>Body-Scan – <em>from MBSR recording</em></td>
<td></td>
</tr>
<tr>
<td>Completed</td>
<td>Child Needs of Therapist</td>
<td>• What the child client needs from the therapist</td>
<td></td>
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<tr>
<td>-----------</td>
<td>--------------------------</td>
<td>--------------------------------------------------</td>
<td></td>
</tr>
</tbody>
</table>
| Not Completed | Reframing practice | • Provide different behaviors a child engages in and ask participant what the child could be communicating?  
• Use examples from participant |
| Completed | Closing | • Read Poem by: Rumi |
| Not Completed | Follow-up | • Participant Questions and Reflections |
| Completed | Review of home practice requirements | • Explanation of the Daily Mindfulness Activity Log and resources |

\[(\frac{\text{completed}}{\text{total}}) \times 100 = \text{Intervention Fidelity}\%\]
**APPENDIX H**

**THERAPIST APPRAISAL QUESTIONNAIRE**

<table>
<thead>
<tr>
<th>Therapist ID:</th>
<th>Session Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client ID:</td>
<td>Session #:</td>
</tr>
</tbody>
</table>

**Therapist Appraisal Questionnaire**

**Directions:** Please complete the sentence “When working with my client today, I felt...” according to your reactions in your session toward this particular client. It is important that you rate the items based on the counseling session you just conducted with this particular client, rather than on your feelings about counseling in general or any of your other clients.

Please indicate your agreement with each item according to the following scale:

<table>
<thead>
<tr>
<th>Not at All</th>
<th>Slightly</th>
<th>Somewhat</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>A Great Deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

When working with my client today, I felt...

1. Happy. (C) 0 1 2 3 4 5
2. Confident. (T)* 0 1 2 3 4 5
3. Angry. (H) 0 1 2 3 4 5
4. Energetic. (C) 0 1 2 3 4 5
5. Disappointed. (H) 0 1 2 3 4 5
6. Eager. (C) 0 1 2 3 4 5
7. Worried. (T) 0 1 2 3 4 5
8. Disgusted. (H) 0 1 2 3 4 5
9. Excited. (C) 0 1 2 3 4 5
10. Exhilarated. (C) 0 1 2 3 4 5
11. Fearful. (T) 0 1 2 3 4 5
12. Sad. (H) 0 1 2 3 4 5
13. Hopeful. (C) 0 1 2 3 4 5
14. Pleased. (C) 0 1 2 3 4 5
15. Anxious. (T) 0 1 2 3 4 5
16. Guilty. (H) 0 1 2 3 4 5

**Note:** The letter in parentheses following each item indicates the TAQ/CAQ subscale to which it belongs (C = Challenge, T = Threat, and H = Harm). * = reverse-scored item.
APPENDIX I

COUNTERTRANSFERENCE MANAGEMENT SCALE

Countertransference Management Scale

With your supervisee in mind, please rate the following items in terms of your supervisee’s behavior in psychotherapy sessions. In rating each item, please use the following 1–5 scale.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

The therapist-in-training...

1. Maintains a firm sense of who s/he is as a person in the sessions.  
2. Has a well-integrated self during sessions.  
3. Uses his/her theoretical understanding of the client-therapist relationship to inform the work during the therapeutic hour.  
4. Can identify the motives behind his/her behaviors in sessions.  
5. Grasps theoretically clients’ dynamics in terms of what goes on in the therapeutic relationship.  
6. Recognizes the boundaries between him/herself and his/her clients during the psychotherapy hour.  
7. Regulates his/her own nervousness well during sessions.  
8. Understands the basis of his/her feelings, thoughts, and behaviors in sessions.  
9. Deeply understands clients from clients’ point of view.  
10. Uses his/her theoretical understanding of clients to inform the work during the therapeutic hour.  
11. Understands how his/her emotions, thoughts, and behaviors in sessions are connected.  
12. Does not let anxiety overwhelm him/her in the psychotherapy hour.  
13. Is able to step into clients’ inner world.  
14. Effectively connects strands of clients’ material in developing conceptualizations of clients.  
15. Has appropriate confidence as a person during the psychotherapy hour.  
16. Effectively sorts out how his/her feelings relate to clients’ feelings.  
17. Presents a consistent sense of self in the therapeutic hour.
<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>18.</td>
<td>Is able to conceptualize clients’ dynamics clearly.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19.</td>
<td>Allows him/herself to feel a range of affect without getting overly anxious.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>20.</td>
<td>Demonstrates calm in the face of difficult client material.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>21.</td>
<td>Understands the basis for own atypical reactions to clients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>22.</td>
<td>Deals effectively with his/her anxiety when working with difficult client problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
APPENDIX J

INVENTORY OF COUNTERTRANSFERENCE BEHAVIORS

Inventory of Countertransference Behavior
(Negative Countertransference Scale Only)

For the 11 items below, please rate the therapist’s reaction to the client during the counseling session using the scale from 1 to 5. Please refer to the clarifying statement below each item and to the examples of possible in-session therapist behaviors to help you make each rating.

<table>
<thead>
<tr>
<th>Little to No Extent</th>
<th>To Moderate Extent</th>
<th>To a Great Extent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

The therapist:

1. Rejected the client in the session_____
2. Was apathetic towards the client in the session_____
3. Behaved as if she or he were ‘somewhere else’ during the session_____
4. Was critical of the client during the session_____
5. Spent time complaining during the session_____
6. Treated the client in a punitive manner in the session_____
7. Inappropriately took an advising tone with the client during the session_____
8. Distanced him/herself from the client in the session_____
9. Behaved as if she or he were absent during the session_____
10. Inappropriately questioned the client’s motives during the session_____
11. Provided too much structure in the session_____
APPENDIX K

YOUNG CHILD SESSION RATING SCALE (YCSRS)