

Therapy outcome and the therapeutic alliance in relation to gender matching and
countertransference

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Abstract

This longitudinal study investigated the effect of gender matching and countertransference on therapy outcome and therapeutic alliance. Patients (N = 97) were divided into a gender matched (n = 51) and non-gender matched (n = 46) condition. No effect of gender matching on therapy outcome and the therapeutic alliance was expected and a negative correlation between countertransference and therapy outcome and therapeutic alliance. Finally, no effect of gender matching on therapy outcome, and the therapeutic alliance was expected after controlling for countertransference. The Outcome Rating Scale (ORS) was administered by patients at every appointment to measure therapy outcome, and the Session Rating Scale to measure therapeutic alliance. Therapists filled out the Interpersonal Circumplex (IMI-C) after each patient-therapist contact to measure countertransference. The results suggested gender matching had no effect on therapy outcome and the therapeutic alliance. This finding remained after adding countertransference as a covariate. Countertransference did not correlate with therapy outcome and therapeutic alliance and no correlations between all variables were found. In future research therapists' variables, as therapy orientation and years of experience should be included. In conclusion this study suggests no particular match on gender appears to be detrimental to therapy outcome and development of the therapeutic alliance, even under the influence of countertransference. In clinical practice this means that patients can be allocated to therapists, regardless of gender, without harming therapy outcome and the therapeutic alliance.

Keywords: gender matching, therapy outcome, therapeutic alliance, countertransference.

Therapy outcome and the therapeutic alliance in relation to gender matching and countertransference

The relation between therapy outcome and the therapeutic alliance has been studied extensively in the past. Therapy outcome-research focuses on the relation between patient progress and a variety of variables, for example demographic variables (e.g. gender, age); specific techniques (e.g. Cognitive Behavioural Therapy, Trauma Focused); or extra therapeutic variables (e.g. social support) (Jones & Zoppel, 1982; Cabral & Smith, 2011; Huppert et al., 2001). The therapeutic alliance refers to the patient-therapists relationship. This term originated in early psychoanalytic theories and can be explained as the bond between patient and therapist and underlines the collaborative relation between patient and therapist to overcome the struggles of the patient. Optimal therapeutic alliance is achieved when patient and therapist share an understanding of beliefs and goals (Lambert & Barley, 2001). Bordin (1979) stated the therapeutic alliance is an essential ingredient of therapy, allowing patients to accept and believe in treatment, which changes their outcome for the better. Horvath (2000) reported establishment of alliance (early) in therapy appears to be vital for better therapy outcomes. Lambert & Barley (2001) stated the therapeutic alliance accounts for 30 per cent of the variance in therapy outcome. Meta-analyses of Martin, Garske and Davis (2000) and Horvath and Symonds (1991) replicated this finding analysing 79 and 24 studies.

Two factors thought to influence therapy outcome and the therapeutic alliance were chosen to be investigated. The first factor was the therapist's gender, and whether this matched the patients' gender or not. The second factor was countertransference, as experienced by the therapist in contact with patients. In the past bivariate relations have been established between the previously mentioned variables, however not in a combined patient-therapist, longitudinal study. By studying these variables, the current study adds to the existing body of research and investigates if assumptions made in regular practice are justified.

In general practice it seems rational to allocate patients based on their gender. Patients and therapists of the same gender are believed to understand each other more thoroughly, which is thought to improve several therapeutic processes. Foundations of this notion can be found in social psychology and gender schema theories (Bem, 1981; Wintersteen, Mensinger & Diamond, 2005). Both studies suggest people identify more easily with individuals similar

to themselves. Which is based on the assumption that patients and therapists of the same gender view the world through the same gender lens, promoting similar views. Patient and therapist dyads can be divided in gender matched (same gender) and non-gender matched (different gender) combinations. Several studies investigated this; subsequently reporting gender matching leads to improved therapy outcome. Cabral and Smith (2011) found this, studying 52 studies in a meta-analysis focused on racial and ethnic matching. As did Jones and Zoppel (1982), who indicated female dyads reported positive outcomes in comparison to non-gender matched dyads. Project MATCH (1998) reported no effect based on two independent samples of 952 and 774 patients receiving therapy for substance abuse disorder. However, gender matched female dyads reported more abstinence and fewer drinks per occasion, which indicated an advance for gender matched dyads. On the other hand, the following studies reported no effect. E.g. Minami et al. (2009) and Wampold and Brown (2005) utilized the Outcome Questionnaire-45.2 (OQ-45.2), a self-report measure, on respectively 6,099 students scoring above clinical cut-off scores and 6.146 patients in a naturalistic setting. Zlotnick, Elkin and Shea (1998) analysed 27 therapists and 203 patients receiving psychotherapy for depression using the short version of the Hamilton Depression Rating Scale (HMSD). Huppert et al. (2001) investigated 14 therapists and 312 patients treated for panic disorder with cognitive behavioral therapy (CBT). Several panic-related measures were collected and evaluated by independent trained clinicians, pre and post treatment. In conclusion, four studies indicated no effect of gender matching on therapy outcome (Huppert et al., 2001; Minami et al., 2009; Wampold & Brown, 2005; Zlotnick et al., 1998). Two studies reported gender matching did influence therapy outcome (Cabral & Smith, 2011; Jones & Zoppel, 1982) and one study reported contradictory findings (Project MATCH, 1998). Both studies in favor of gender matching had methodological issues. Studies indicating no effect are comparable to the current study as measurements and patients investigated are alike. Therefor the following hypothesis is proposed: Gender matching does not influence therapy outcome.

As stated before, therapy outcome and therapeutic alliance are intertwined. It seems reasonable to investigate the effect of gender matching further, and to include the therapeutic alliance. Beutler, Clarkin, Crago and Bergan (1991) reason gender matched dyads experience more therapeutic alliance, as similarities enhance the patient's perception of their therapist resulting in a more helpful relationship. A randomized clinical trial (RCT) by Wintersteen, Mensinger and Diamond (2005) replicated this finding examining 600 adolescents. Gender-

matched dyads reported stronger therapeutic alliances on the Working Alliance Inventory (WAI). As did Johnson and Caldwell (2011) who investigated 182 marriage and family therapists and 233 patients receiving individual, couple or marriage therapy. Measurement and administration of the therapeutic alliance took place after the fourth session. On the other hand, Dolinsky, Vaughan, Luber, Mellman and Roose (1998) reported patients perceived the relation with their therapist as positive, irrespective of a sense of similarity, based on 50 therapy dyads. Evans-Jones, Peters and Barker (2009) reported the same finding studying 24 dyads treated for psychosis with CBT. As did Bhati (2014), investigating 92 patients diagnosed with Axes 1 mood disorders in a naturalistic setting. The studies of Bhati, (2014), Dolinsky et al. (1998) and Evan-Jones et al. (2009) are comparable to the current study as patient characteristics and methods are comparable. On the contrary, Johnson and Caldwell (2011) and Wintersteen, Mensinger and Diamond (2005) studied a vastly different population. Because of the above it is expected that gender matching does not influence the therapeutic alliance.

As stated, this study focused on two therapist variables. The first variable, gender matching, has received adequate addressing in the previous paragraphs however the second variable has not. Countertransference is characterized as the therapist's internal and external reactions to patients and is determined by the therapist's personal vulnerabilities and unresolved conflicts (Hayes, Gelso & Hummel in Norcross, 2010). It seems almost logical to assume countertransference influences therapy outcome and the therapeutic alliance. Nevertheless, scientific reasoning is absent when assuming: Capitalizing once again the importance to scientifically substantiate claims. Countertransference was first studied by Freud (1910), Freud believed countertransference was harmful as it was a product of the unconscious mind of the therapist. Later in time, countertransference came to be seen as an important tool for therapists to improve their understanding of patients. Currently, a mixed view is in place: countertransference is regarded as an obstacle which may hinder therapy, but also as a tool for professional and personal development of the therapist. It can guide the therapist towards a better understanding of the patient, thus improving therapeutic processes (Lecours, Bouchard & Normandin, 1995). Two different meta-analytic studies reported countertransference reactions are related inversely and modestly to therapy outcome, based on respectively seven and three studies (Hayes, Gelso & Hummel, 2011; Hayes, Gelso, Goldberg & Kivlighan, 2018). Another meta-analysis by Gelso and Hayes (2010), of seven studies on countertransference management and therapy outcome, reported a large effect ($r = .56$). This

study suggested countertransference management led to improved therapy outcome. Gelso and Hayes (2001) concluded therapy outcomes were negatively influenced by countertransference, and positively influenced by countertransference management. Fuertes, Gelso, Owen and Cheng (2013) analyzed several therapy dyads. Less successful dyads reported more fluctuation and increased countertransference. In a study of 20 therapy dyads Hayes, Riker and Ingram (1997) reported countertransference was negatively related to therapy outcome in unsuccessful cases, rated by therapists and their supervisors. Williams et al. (1997) found therapists' countertransference influenced their ability to ascertain maximum effectiveness. In sum several meta-analytic studies found a negative, moderate effect of countertransference on therapy outcome (Hayes, Gelso & Hummel, 2011; Hayes, Gelso, Goldberg & Kivlighan, 2018). Another study reported countertransference management, which seems equivalent to reduced countertransference in a trivial way, led to improved therapy outcomes (Gelso & Hayes, 2001). Other studies reported countertransference only led to reduced therapy outcome in less successful cases (Fuertes et al., 2013; Hayes, Riker & Ingram, 1997). Additionally, Williams et al. (1997) found countertransference interferes with improving therapy outcome. As these studies have different results a middling view is proposed: Countertransference has a negative relation with therapy outcome. This suggests as countertransference increases, therapy outcome decreases.

In the same line of thought the relation between countertransference and the therapeutic alliance is investigated. A review by Machado et al., (2014) evaluated three studies covering countertransference and the therapeutic alliance, and reported conflicting results. The first study found a positive correlation, studying 25 experienced psychotherapists. The second study was completed in an outpatient clinic for psychology students and reported a negative correlation. Lastly, the third study reported a moderately high, positive correlation in the therapist version, but a weak correlation in the patient version (Machado et al., 2014). Ligiere & Gelso (2000) found a negative correlation between countertransference and the therapeutic alliance. Fuertes, Gelso, Owen & Cheng (2013) reported lower levels of countertransference corresponding with a better therapeutic alliance, indicating a negative correlation, using both patients' and therapists' measures. Therapists could either have trouble forming an emotional bond (therapeutic alliance) due to countertransference, or a poor therapeutic alliance could lead to increased countertransference. As not much research has been done on these variables it's difficult to form a conclusive hypothesis. Remembering countertransference is seen as a therapist variable in the current study, studies using

therapists' measures are given more weight (Machado et al., 2014; Gelso et al., 2013). Consequently, countertransference is thought to have a negative relation with the therapeutic alliance. This suggests, as countertransference increases, the therapeutic alliance decreases.

All bivariate relationships have been established. Nonetheless, the remaining, comprehensive relations remain ambiguous. As therapy outcome, the therapeutic alliance, gender matching and countertransference have yet to be examined as a whole, no immediate answer is available. An in-depth study of patients with eating disorders indicated gender matching is thought to influence countertransference, as there is a difference between female and male therapists on female patients. Countertransference was reported to have a negative effect on the therapeutic alliance (Gelso et al., 2013; Kaplan & Garfinkel, 1999; Machado et al., 2014). Gender matching and countertransference were both reported to influence therapy outcome negatively (Zuzino, Agoos, & Davis, 1990). In sum it is expected gender matching does not influence therapy outcome and the therapeutic alliance. However, as Kaplan and Garfinkel (1999) states gender matching influences countertransference, countertransference is treated as a covariate. It is expected there is no effect of gender matching on therapy outcome, and no effect of gender matching on the therapeutic alliance while controlling for countertransference.

On an additional note: The terms 'therapy outcome' and 'therapeutic alliance' were utilized in the introduction whilst searching fitting literature. As analysis progressed these terms appeared to be unfitting. As both variables were administered on several occasions over a period of six months more befitting terms would be *improvement in therapeutic wellbeing* (therapy outcome) and *therapeutic alliance improvement* (therapeutic alliance). Both terms will be utilized in the following paragraphs.

In essence the purpose of this study is to answer the following question: what is the effect of gender matching and countertransference on therapy outcome, and the therapeutic alliance? The question was answered utilizing therapists' and patients' reports. Based on existing research, the following hypotheses were generated:

1. No effect of gender matching on therapy outcome.
2. No effect of gender matching on the therapeutic alliance.
3. Countertransference has a small, negative effect on therapy outcome.
4. Countertransference is negatively correlated with therapeutic alliance.

5. No effect of gender matching on therapy outcome, when controlling for countertransference.
6. No effect of gender matching on therapeutic alliance, when controlling for countertransference.

Method

Design and Procedure

During a three-month period 147 patients were recruited at a mental health institution in Tiel. All patients over 18 years of age, that were patient of a participating therapist, receiving individual therapy were eligible to participate. The study took place over a period of six months, divided into three periods of two months. T1, consisting of the first two months, patients were asked to score their *therapeutic wellbeing* (therapy outcome) and the therapeutic alliance when they had an appointment. During T2 (months 3 and 4) patients continued to fill out the same questionnaires as T1. Therapists were now instructed to register their countertransference reactions after each appointment. During the final two months (T3) patients and therapists continued filling out both questionnaires. In T3 therapists were instructed to view and discuss together with the patient, how the patient scored their therapeutic wellbeing and the therapeutic alliance. Patients were reminded to fill out their questionnaires via the front office, therapists via the Electronical Health Record. Patients reported on several accounts “they didn’t feel like filling in the questionnaire” or it was “too much of a hassle”. Questionnaires were filled out using pen and paper.

Most of the patients were treated by multiple therapists: Weekly psychologist appointments and pharmacotherapy appointments every two months or so with a psychiatrist. As a result, a complicated network of data originated with irregular administrations and different therapists. To create a useable dataset, data was inspected to see which patients had a complete dataset consisting of two measures of therapeutic wellbeing, the therapeutic alliance and one administration of countertransference (filled in by the therapist) about the relationship with the same therapist. Due to the comprehensiveness of the dataset it was possible to measure change in therapeutic wellbeing and therapeutic alliance over time. The largest possible period of time between two measures of therapeutic wellbeing and the therapeutic alliance was used with a minimum of two weeks and a maximum of twelve weeks. Countertransference was seen as a therapist variable; the initial measure served as baseline.

Patients

Patients were recruited at a mental health institution in Tiel and were informed via flyers and word of mouth of the study. In total, 147 patients aged 48.82 ($SD = 14.67$) agreed to participate. All participating patients signed an informed consent, informing them the purpose of the study was to improve treatment, as well as to inform them of the ability to withdraw their permission to participate at any given time. Patients were not compensated for participation. 42 patients were excluded for several reasons: too many missing values (24 patients); withdrawal of permission (15 patients) and answering too many questions incorrectly (3 patients). The remaining participants ($N = 97$) were aged 18 to 82 ($M = 46.42$, $SD = 15.01$). Patients were predominantly from the Netherlands ($n = 94$). All patients received education, ranging from lower secondary education to university. All patients ($N = 97$) had been classified with at least one DSM-5 classification. Most prevalent were depression related disorders (53.6%) followed by panic and anxiety disorders (11.3%). Additional patient variables are shown in Table 1.

Therapists

In total 7 therapists (4 males and 3 females) participated; 1 male psychiatrist, 2 female psychiatrists, 3 male and 1 female psychologists. 1 Employee was a clinical psychologist, 2 were in post-master healthcare training, and 1 psychologist was master level trained. Both psychiatrists were doctoral-level employees. The average age was 41.42 ($SD = 12.68$). Therapist received no compensation or additional time to fill out the questionnaire whilst participating.

Table 1

Patient characteristics, n and percentages

Variable	<i>n</i> (%)
Nationality	97 (100%)
Netherlands	94 (91.1%)
Turkey	2 (1.9%)
United Kingdom	1 (1%)
Educational level	96 (100%)
Secondary school, 1 st phase middle	10 (10.0%)
Secondary school, 2 nd phase low	10 (10.0%)
Secondary school, 2 nd phase middle	14 (14.4%)
Secondary school, 2 nd phase high	15 (15.5%)

Table 1 Continued

Higher education, 1 st phase high	10 (10.0%)
Other	37 (40.1%)
First diagnosis	97 (100%)
Depression related disorders	52 (53.6%)
Panic and Anxiety disorders	11 (11.3%)
Post-Traumatic Stress Disorder	7 (7.3%)
Other	27 (27.8)
Second diagnosis	75 (100%)
Personality disorders	19 (25.3%)
Somatoform disorders	16 (21.3%)
Autism	7 (9.3%)
Post-Traumatic Stress Disorder	7 (9.3%)
Other	26 (34.8%)
Third diagnosis	18 (100%)
Personality disorders	5 (27.8%)
Somatoform disorders	4 (22.2%)
Panic and Anxiety disorders	3 (16.7%)
Other	6 (33.3%)
Fourth diagnosis	4 (100%)
Personality disorders	2 (50%)
Somatoform disorders	2 (50%)

Measures

Therapeutic wellbeing.

The outcome rating scale (ORS) is a routine outcome measurement (ROM) asking patients to evaluate therapeutic progress in terms of personal distress, interpersonal wellbeing, social role and overall wellbeing at the beginning of the session. The four items are rated on a scale ranging from 0 to 100 millimeter(s) with the instruction to place a mark on each line to score their feelings when thinking about the past week. The low estimate is to the left and the high estimate to the right. The total score is obtained by summing all four scales together, with a minimum score of 0 (millimeters) and a maximum score of 400 (millimeters). Every first and final administration of each patient were selected, after which the four subscales were summed up to compute the total score for the first and final measure (see Table 2). To obtain a balanced understanding of the development over time, the total score of the first administration was subtracted from the score of the final administration. Which created a new variable, stating the degree in improvement in therapeutic wellbeing over time as rated by the

patient. A positive value indicated an improvement, a negative value indicated a decline. Miller, Duncan, Brown, Sparks and Claud (2003) reported a Cronbach's alpha of .91 for the first administration and .97 for the third administration of their study. The current research had a Cronbach's alpha of .91 for the first and .94 for the final administration.

Therapeutic Alliance.

Using the Session Rating Scale (SRS) patients were asked to evaluate their view on the therapeutic alliance with a four-item questionnaire measuring respect and understanding, relevance of goals and topics, client-practitioner fit and overall alliance. The four items were rated on a scale ranging from 0 to 100 millimeters instructions to place a mark on each line with a low estimate to the left and high estimate to the right. The four items are summed up to compute a total score, with a maximum of 400 millimeters. Patients were asked to fill out the SRS at the end of the session. For every patient, the first and final administration in the dataset was selected whereupon the four subscales were summed up to compute the total score for the first and final measure. To obtain a balanced understanding of the development over time, the total score of the first administration was subtracted from the score of the final administration. This creates a new variable: the degree of improvement in therapeutic alliance over time as rated by the patient. A positive value indicated an improvement, a negative value a decline. Fuertes et al. (2013) reported internal consistency alpha coefficients of .86. Cronbach's alpha was .91 for the first administration, and .94 for the last administration. According to Fuertes et al. (2013) alliances tend to be stronger at the beginning of therapy.

Gender matching

Each patient was asked to indicate their gender. All patients referred to themselves as being in a traditional gender role (either female or male). In total 65 female and 32 male patients participated. Of the therapists there were 3 females and 4 males. 51 Patients were in a gender matched condition (47.4%), 46 were in a non-gender matched condition (47.4%).

Table 2

Patient clinical characteristics at first, final and computed measure of therapeutic wellbeing and therapeutic alliance

Measure	Subscales	First administration (M, SD)	Final administration (M, SD)	Degree of improvement (M, SD)
Therapeutic wellbeing	Personal distress	53.8, 28.3	58.7, 28.9	4.9, 28.8
	Interpersonal wellbeing	60.5, 27.0	64.7, 27.4	4.2, 29.4
	Social role	57.6, 29.0	59.1, 29.0	2.0, 27.7
	Overall well-being	55.0, 26.8	60.4, 27.2	5.4, 29
	Total	226.0, 98.1	242.9, 104.2	18.4, 96.6
Therapeutic alliance	Respect and understanding	82.2, 18.0	81.6, 19.5	-.57, 23.4
	Goals and topics	84.3, 16.8	84.1, 16.4	-.15, 21
	Client-practitioner fit	83.9, 16.7	84.2, 15.4	.25, 20.4
	Overall alliance	87.2, 14.3	86.8, 14.9	-.36, 20.2
	Total	337.6, 58.2	336.8, 61	-.82, 75.1

Note. Patients rated each measure on a 0 to 100 scale. The four subscales are summed up to compute the total score. The degree of improvement was computed by subtracting the first administration from the final administration.

Countertransference

Therapists were asked to rate their feelings of countertransference towards their patients using the Dutch adaption of the short version of the Impact Message Inventory-Circumplex. The 32-item questionnaire is designed to appraise patients' communication relationships as interpreted by the therapist. It measures the inner experiences of the therapists based on their interactions with the patient (Hafkenscheid & Rouckhout, 2009). Each item is measured on a four-point scale ranging from none (1) to very much (4), with a maximum score of 128. For example: "when I am with this person, he makes me feel that ... I should tell him to stand up for himself". The IMI-C consists of four subscales: Dominant, Hostile, Submissive and Friendly and is based on two basic dimensions of human interaction and communication: the dimension 'Hostile-Friendly' (the vertical axis of the interpersonal

circle) and the dimension 'Dominant-Submissive' (Hafkenscheid, 2015). Raw scores on the scale 'Submissive' were deducted from the scores on the scale 'Dominant' to create the scale 'Countertransference Dominant-Submissive' (CDS). Raw scores on the scale 'Hostile' were deducted from scores of the scale 'Friendly' to compute the scale 'Countertransference Hostile-Friendly' (CHF). Therapists were asked to score the questionnaire right after patient-therapist contact. A timeframe of 24 hours was imposed to fill out the questionnaire. The reasoning for this time limit is that after a while, initial feelings felt during the contact, will disperse. Hafkenscheid & Rouckhout (2009) reported Cronbach's alpha for each scale ranging from .65 to .84. The current study had a Cronbach's alpha of .88. 1 therapist assessed 36 patients, 3 therapists assessed between 12 and 15 patients, 3 therapists assessed less than 9 patients.

Data processing and analysis

Independent t-tests are run to test hypothesis 1, no effect of gender matching on therapeutic wellbeing, and hypothesis 2, no effect of gender matching on the therapeutic alliance. A Pearson's r is performed to test hypotheses 3: Countertransference has a small negative effect on therapeutic wellbeing and hypotheses 4: Countertransference is negatively correlated with therapeutic alliance. Furthermore, two ANCOVA's are performed to test hypotheses 5 and 6: No effect of gender matching on therapeutic wellbeing, when controlling for countertransference, and no effect of gender matching on the therapeutic alliance when controlling for countertransference.

Results

Before testing, checks were carried out to ensure assumptions of parametric analysis were met. Transforming data into z-scores indicated 95% of the data fell into the normal range. Data exceeding a value of 3.3 times the standard deviation were considered outliers and excluded from analysis. This resulted in excluding data of one participant for therapeutic alliance, and one participant on CDS. All other variables were found to be normally distributed.

Hypothesis 1 was: Gender matching has no effect on therapeutic wellbeing. On average, patients in the gender matched condition ($M = 26$, $SE = 14.35$) rated their therapeutic improvement greater than patients in the non-gender matched condition ($M = 9.9$, $SE = 13.44$) as is shown in Table 3. This difference, -16.02 , BCa 95% CI $[-54.35, 20.54]$ was

not significant $t(94) = -.808, p = .261$. The effect size was 0.08. Hypothesis 1 is confirmed: According to this study gender matching has no effect on therapeutic wellbeing.

Hypothesis 2 was: Gender matching has no effect on the therapeutic alliance. On average, patients in the gender matched condition ($M = -10.6, SE = 9.6$) rated the therapeutic alliance lower than patients in the non-gender matched condition ($M = 7.3, SE = 10.4$), as is shown in Table 3. This difference, 17.86, BCa 95% CI [-8.86, 45.02] was not significant $t(94) = 1.26, p = .775$. The effect size was small; 0.13. Hypothesis 2 is confirmed; according to this study gender matching has no effect on the therapeutic alliance.

Table 3

T-test results for the effect of gender matching on therapeutic wellbeing and therapeutic alliance

Variable	Gender matched dyads (n = 51) M, SD	Non gender matched dyads (n = 46) M, SD	t-value	df	<i>P (two- tailed)</i>
Therapeutic wellbeing	26, 102	9.9, 90.2	-.81	94	.421
Therapeutic alliance	-10.6, 68.4	7.3, 69.9	1.26	94	.210

Hypothesis 3 was: Countertransference has a small, negative effect on therapeutic wellbeing. There was a non-significant positive relation between therapeutic wellbeing and CDS $r = .044, n = 85, p = .687$. There was a non-significant negative relation between therapeutic wellbeing and CHF $r = .069, n = 85, p = .531$. Both measures of countertransference had no significant influence on therapeutic wellbeing. Therefore, the hypothesis is rejected.

Hypothesis 4 was: Countertransference is negatively correlated with therapeutic alliance. Therapeutic alliance has a non-significant negative relation with CDS $r = -.040, n = 86, p = .715$ and CHF $r = -0.38, n = 68, p = .726$. A negative relation was established, however as this finding is not significant it could be due to chance, therefore the hypothesis is rejected.

In Table 4 an overview is given of all relations between therapeutic wellbeing, therapeutic alliance and countertransference. CDS was found to correlate with CHF, $r = -.213, n = 85, p = .050$.

Table 4

Correlations between therapeutic wellbeing, therapeutic alliance, countertransference dominant-submissive and countertransference hostile-friendly

Variable	Therapeutic wellbeing	Therapeutic alliance	Countertransference Dominant-Submissive	Countertransference Hostile-Friendly
Therapeutic wellbeing	1.00			
Therapeutic alliance	.051	1.00		
Countertransference Dominant-Submissive	.044	-.040	1.00	
Countertransference Hostile-Friendly	.069	-.038	-.213*	1.00

Note: * $p < .05$

Hypothesis 5 states no effect of gender matching on therapeutic wellbeing after controlling for countertransference. The covariates, both measures of countertransference, were not significantly related to the therapeutic wellbeing as was hypothesized. The first scale of countertransference: CDS $F(1, 81) = .002, p = .969, r = .004$ and the second scale: CHF $F(1, 81) = .315, p = .576, r = .06$. There was no effect of gender matching on therapeutic wellbeing after controlling for both measures of countertransference $F(1, 81) = .216, p = .644, \text{partial } \eta^2 = .002$. Planned contrasts revealed that patients non-gender matched condition rated their therapeutic wellbeing more poorly than gender matched patients $t(81) = -10.14, p = .645, r = .75$. This finding is in line with the hypothesis.

Hypothesis 6 states there is no effect of gender matching on therapeutic alliance, after controlling for countertransference, the covariates being both measures of countertransference. The first measure of countertransference (CDS) proved non-significant $F(1, 82) = .147, p = .703, r = 0.02$ as did the second measure (CHF) $F(1, 82) = .267, p = .607, r = .03$ to the therapeutic alliance. Additionally, no effect of gender matching on the therapeutic alliance after controlling for both measures of countertransference was reported $F(1, 82) = 1.12, p = .293, \text{partial } \eta^2 = .53$. Planned contrasts revealed that patients in the non-gender matched condition rated the therapeutic alliance higher than patients in the gender matched condition $t(82) = 16.84, p = .296, r = .82$. This finding is in line with the hypothesis.

Discussion

This study assessed the effect of gender matching and countertransference on therapeutic wellbeing and the therapeutic alliance in a naturalistic setting with 7 therapists and 97 patients. The results confirmed therapeutic wellbeing and the therapeutic alliance are not affected by gender matching (hypothesis 1 and 2). No negative relation between therapeutic wellbeing was reported (hypothesis 3), neither for therapeutic alliance (hypothesis 4). Hypothesis 5 stated no effect of gender matching on therapeutic wellbeing after controlling for countertransference. Analysis confirmed this is correct. Lastly, it was reported gender matching does not affect the therapeutic relation after controlling for countertransference as expected (hypothesis 6).

Therapeutic wellbeing is not influenced by being in a gender matching as Huppert et al. (2011); Minami et al. (2009); Wampold and Brown (2005) and Zlotnick et al. (1998) reported. However, patients in the gender matched condition rated on average therapeutic wellbeing 17 points higher (on a 400-point scale) than non-gender matched patients. This trend remains present inspecting the dataset as a whole, comparing gender matched dyads to the overall average of both groups. This finding is in line with Project MATCH (1998) were but several non-significant advantages were seen in the gender matched group. Perhaps, having a therapist of the same gender does implicate certain advantages. It would be interesting to investigate what might be the cause of this difference and how to utilize it fully.

In line with Bhati, (2014); Evan-Jones et al. (2009) and Dolinsky et al. (2009) this study reported the therapeutic alliance to be unaffected by gender matching. Gender matched dyads rated the therapeutic alliance 17.9 points lower than non-gender matched dyads. Inspecting the data more thoroughly revealed patients of gender matched dyads did so on all four subscales on the final measure in comparison to the first measure, resulting in a decrease in therapeutic alliance. It is imaginable discussing intense, personal subjects, and being guided to a new way of thinking causes stress between patient and therapists, causing patients to give a lower rating. However, on average, the score of the therapeutic alliance was static over time. Which is contradicting Gersh et al. (2017) who imposes therapeutic is known to vary throughout treatment. This could be due to patients having different timeframes, ranging from two weeks to three months, over which the change in time was computed. Providing a more structured plan to measure at certain set timeframes (for example once a month) would sidestep this.

On the measure therapeutic wellbeing enormous deviations were seen, exceeding the average score 10 to 50 times, after deleting outliers. Perhaps utilizing a more stringent norm (for example excluding deviations greater than 2.7 instead 3.3) would lead to smaller deviations. Further inspecting of the dataset led to the observation of much comorbidity and personality disorders. Disorders such as schizophrenia were absent. It is up for discussion whether the patients participating, were an actual representation of the real world. Additionally, the overall improvement in therapeutic wellbeing and therapeutic alliance was marginal at best. In therapeutic wellbeing this is undesirable, as the goal of therapy is to reduce and eliminate symptoms, improving the quality of life, not maintaining. In a more positive view, therapeutic wellbeing did not diminish over time. Gersh et al. (2017) indicated fluctuations in therapeutic wellbeing are normal. This study took place in a specialized mental health facility, treating predominantly severe psychotherapeutic patients, a vastly different population than students scoring above clinical cut-off (Minami et al., 2009). Perhaps six months was too short to see change over time in this specific population.

Regarding countertransference, a number of the current findings concur with previous research (e.g. Colli & Ferri, 2017; Hayes et al., 2011; Hayes et al., 2018; Gelso & Hayes, 2014). It seems countertransference has no effect on therapeutic wellbeing and therapeutic alliance as no relations were found running a Pearson r correlation. In other studies, a negative relation was found between countertransference and therapeutic wellbeing and the therapeutic alliance. Those studies assessed countertransference using clinicians, observers and supervisors' feedback, investigating specific levels of countertransference such as feelings of 'dominance' and 'overwhelmed'. As countertransference is intertwined with the therapist's vulnerabilities and unresolved conflicts (Hayes, Gelso & Hummel in Norcross, 2010) it is bound to change over time. In the future countertransference should be investigated over time. At the time analyses were run, Anton Hafkenscheid's instrument to compute subscales of the IMI-C wasn't optimized and couldn't be used. It seems plausible that the current study would have had other results if this instrument was used instead of manufacturing a new method.

Adding countertransference as a covariate had no effect on therapeutic wellbeing and therapeutic alliance as was expected. However, differences between both scales of countertransference submerged. Especially the CHF in comparison to CDS had greater effect sizes. This is proven interesting as one scale measures 'hostile-friendless' and the other 'dominant-submissiveness'. Apparently, hostility and friendliness play a more important role in therapy than dominance and submissiveness. On both therapeutic wellbeing and the

therapeutic alliance large but non-significant effect sizes were found. Both findings indicate this study didn't have enough power and further studies need to include more participants. Adding countertransference as covariate was solely based on one study by Kaplan and Garfinkel (1999). As stated before, it is up for discussion whether measuring countertransference in this study happened in a methodically sound way and how this influenced the results. It seems countertransference had less influence on therapeutic wellbeing and therapeutic alliance than is assumed in general practice, however this finding should be interpreted with great caution as much more research is needed to justify this claim.

A number of limitations need to be stated. Patients weren't randomly assigned to therapists. Allocation based on gender happened frequently. Several variables such as therapists' years of experience and type of treatment delivered and patient variables as years of therapy (Jones & Zoppel, 1982; Cabral & Smith, 2011; Huppert et al., 2001), were not taken into account. More experienced therapists may see a greater proportion of patients with a poorer prognosis. More specifically a distinction between psychologists and psychiatrists needs to be made as both treat different patients with different perspectives. Due to the many administrations, change over time could be computed, making this a longitudinal study. But it almost imposed an incredible burden on employees. For the future it would be advisable to take note of the above-mentioned recommendations and utilize all measured data, or to lessen the burden on the front office and therapists by diminishing the administration rate, especially if data is not used.

In clinical practice this study suggests no particular match on gender appears to be detrimental to therapeutic wellbeing and the therapeutic alliance, with or without controlling for countertransference. In clinical practice this means patients can be allocated to a therapist, regardless of gender, without harming therapeutic wellbeing and the therapeutic alliance. In this study, countertransference does not influence therapeutic wellbeing and the therapeutic alliance and can be treated as a helpful tool for therapy (Lecours, Bouchard & Normandin, 1995).

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