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Reflective Practice strategies for clinical psychology students: Understanding and managing personal responses in professional roles

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Introduction

Background to the study

The ability to engage in reflective practice is a core competency of Psychologists and also other professional groups. This ability is emphasised in all professions as it contributes to safe and effective practice. There is a body of research that suggests that this may be particularly challenging for professionals who work in therapeutic situations where the helping relationship can become intense and challenging. Research demonstrates that the experience of countertransference (CT; or emotional responses to clients that can result in problematic therapist behaviours) is a normal part of the therapist's experience – however it can also be one of the most challenging aspects of working therapeutically. A recent review of the literature concluded that the therapist's ability to manage his or her own emotional responses influences therapy outcomes for clients (Hayes, Gelso & Hummel, 2011). Engaging in CT behaviours (such as being critical, becoming overly involved, or feeling overwhelmed by a client's problems) has negative effects on the client and on therapy outcomes. On the other hand, being able to understand and manage these emotional responses is associated with a positive therapeutic relationship, which in turn is associated with better therapy outcomes (Hayes et al., 2011).

There is evidence that trainee therapists sometimes experience difficulty understanding and managing their emotional responses to clients. This was evident in a study of clinical psychology students' reports of CT when working with clients (Cartwright, Rhodes, King & Shires, 2014). The students were

able to describe how they were feeling when working with clients but were often confused as to why they had such strong reactions in some situations and also did not know how to manage their reactions.

There is evidence that therapists and trainee therapists vary in their ability to manage CT (Hayes et al., 2011). However, little, as yet, is known about the factors that facilitate CT management (Hayes et al., 2011). Two independent studies conducted with trainee therapists examined a two-part model that proposed that therapists who are more aware of their CT feelings *and* have a theoretical framework for understanding these feelings will engage in less CT behavior (Latts & Gelso, 1995; Robbins & Jolkovsky, 1987). It was proposed that a theoretical framework for understanding CT is important as it allows the therapist to cognitively process CT, which in turns facilitates management (Robbins & Jolkovsky, 1987). In both of these studies, trainees viewed video therapy sessions and were asked to rate their responses as therapists to the clients at intervals across the sessions. The two-part model was supported in both studies where trainees' awareness of CT in combination with a conceptual or theoretical framework for understanding CT resulted in the lowest levels of CT behavior (Latts & Gelso, 1995; Robbins & Jolkovski, 1987). On the other hand, having a strong conceptual framework without personal awareness of CT responses was associated with the highest levels of CT behaviors (Latts & Gelso, 1995; Robbins & Jolkovski, 1987).

The current study aimed to introduce clinical psychology students to the concepts that are used by experienced therapists. It aimed to increase students' awareness of their CT responses and to provide them with a method

for understanding the CT. Further, it aimed to provide them with some strategies for managing their CT. This project is particularly important as New Zealand (and Australian) clinical psychology training programmes offer training in cognitive-behavioural therapy (CBT) and related approaches (Kazantzis & Munro, 2011), and these therapies do not offer training for students in regard to CT.

Finally, it is important to note that the majority of clinical psychology programmes in New Zealand include a broad range of students from different backgrounds, including Māori and Pacific Island students. This project aimed to ensure that the teaching and learning methods are culturally appropriate for Māori and Pasifika students. A Māori clinical psychologist and a Pasifika clinical psychologist provided cultural consultation to ensure the cultural appropriateness of the Reflective Practice Guide and teaching approach. Both of these advisers had completed the training previously.

Overview of the study

The teaching and learning approach to CT evaluated in this study was developed by the first author, Claire Cartwright, and has been previously piloted with a group of Auckland psychologists in 2008-2009 (Cartwright & Read, 2011) and with clinical psychology students at three universities in Australia and the University of Auckland in 2013 (Cartwright, Rhodes, King & Shires, 2015). Following the pilot study with students, the teaching approach was revised.

The current study of the teaching approach was influenced by action research methods. According to Reason and Bradbury (2001), action research is “a

participatory democratic process" that aims to develop knowledge in regard to issues that are of concern to people (p.1). Action research involves processes of action and reflection, theory and practice, in participation with others. The people who were engaged in this current study were academic staff from clinical psychology programs in New Zealand and clinical psychology trainees. The "concern" at the centre of the study was the enhancement of trainees' understanding and management of CT.

In 2014, Psychology Clinic Directors and Academics from University Clinical Psychology programmes were invited to take part in a national study of the teaching and learning approach to understanding and managing CT. These included the University of Otago, Canterbury University, Victoria University, University of Waikato, Massey University in Auckland, and University of Auckland. In December 2014, eleven representatives from the six Universities met at the University of Auckland for a two-day workshop to examine the teaching approach and to consider its applicability for the clinical psychology curriculum in New Zealand. This was made possible by the Ako Aotearoa Grant.

The approach was introduced on the first day, as it is taught to students at the University of Auckland, and then reviewed on the second day. An initial draft of the Reflective Practice Guide, developed for the study, was also discussed and any problem areas were defined. Following the two-day meeting, five of the six University clinical psychology programmes decided to include the teaching into their curriculum in 2015. An academic from each University was nominated to facilitate the inclusion of the teaching and to take part in

evaluating the study. While it was initially planned that the University programmes would then trial the teaching approach themselves, all of the Universities requested that Claire Cartwright teach it to their students for the first year in order for them to become more familiar with the approach. The programmes also decided on either a one-day course or a two-day workshop.

The cultural consultation process was then undertaken. A Māori Clinical Psychologist and a Pasifika Clinical Psychologist who had completed the workshop also reviewed the Reflective Practice Guide and gave feedback on both. They both reported that they had experienced the workshop as helpful and that they thought it was culturally appropriate. They also provided some ideas in regard to adapting the approach when working with Māori and Pasifika clients. These are included in the Reflective Practice Guide and in the teaching approach.

The workshops were then completed at the five Universities between April and November, 2015. The timing of each workshop was selected by the Universities to fit into their teaching programmes. The students were sent the Reflective Practice Guide ahead of time so that they could become familiar with the new concepts prior to the workshop. Approximately two to three weeks following each workshop, students who had participated were sent a link to an anonymous online questionnaire that asked them to evaluate the workshop and the teaching and learning approach. At the end of the academic year, academic participants were sent a link to an online questionnaire that asked them to evaluate the teaching and learning approach and its impact of student learning.

The teaching and learning approach is presented below followed by the study's methods, results and discussion.

Reflective Practice: Understanding and Managing Countertransference

The teaching and learning approach and the activities that students engaged in is outlined below. It is useful to also read the Reflective Practice Guide that was developed to accompany the teaching. It illustrates some of the ideas in more depth.

Monitoring and being aware of countertransference responses

This first stage aimed to increase openness to the notion of CT and awareness of CT feelings and thoughts. Initially, trainees were introduced to two studies that examined reports of CT experiences – one study of trainees' experiences of CT (Cartwright et al., 2014) and the second of psychiatrists and clinical psychologists' reports of CT (Betan, Heim, Conklin & Westen, 2006). They were then introduced to definitions of transference and CT from different therapeutic perspectives. Transference refers to the attitudes and behaviours of the client towards the therapist that are based on past relationships; for example, a client may transfer negative thoughts and feelings, which originated in a problematic relationship with a parent, onto the therapist. CT refers to the therapist's thoughts, feelings or behavioural responses to the client. The concepts of positive CT (such as wanting to look after a client or becoming

overinvolved with a client) and negative CT (such as having critical thoughts or withdrawing from a client) were introduced and the potential problems of acting on both positive and negative CT were discussed.

Activity: Trainees were initially asked to take turns talking about a positive CT they had experienced when working with a client. This process was then repeated with a negative CT. The trainer also talked about some personal CT experiences. This activity aimed to normalise CT, increase awareness of potential CT responses, and to support trainees to become comfortable talking about CT.

Understanding objective and subjective countertransference

During this step, students were introduced to the concepts of objective and subjective CT. Shafranske and Falender's (2008) definition of these two aspects of CT was used, as this is complementary to a CBT perspective. The authors define objective CT as the therapist's reactions that are induced by the client's perceptions, affects, and behaviours. These therapist CT responses are consistent with the responses of significant others, such as family and friends, towards the client. Subjective CT, on the other hand, are maladaptive reactions coming from personal factors of the therapist (Shafranske & Fallender, 2008). These originate from the therapist's own unresolved issues, sensitivities, or biases. Objective CT can be seen as a realistic response to the behaviours of a client, nevertheless, these CT responses can be difficult to recognise and understand (Safran & Muran, 2000). Examples of objective CT include a therapist feeling angry with a client who always comes late, a

therapist feeling hurt when a client criticises him or her, or a therapist withdrawing from a client who is distant and uncommunicative.

Both aspects of CT are viewed as cognitive-affective responses of the therapist that can manifest in CT behaviours if not managed successfully. It is important to note however that not all emotional responses of the therapist can be considered countertransferential. As well as subjective and objective CT, it is important to consider a third set of therapists' emotional responses that can be described as "real" – unique to the relationship with the client and free of any distortion on the part of the therapist (Kiesler, 2001). This could include such responses as sadness for a client who speaks of his grief, happiness for a client who has had a success after considerable struggle, or amusement at a client's funny joke.

While the training was mainly aimed at providing a systematic way of conceptualising objective CT, the importance of subjective CT was also emphasised and students were encouraged to consider how their own personal sensitivities may contribute to their responses to clients. Students may choose to have their own therapy to explore the unresolved issues, sensitivities, or biases that might emerge in their work as therapists.

Activity: A client vignette was used to facilitate discussion about possible transference and CT responses. Students were encouraged to consider the client's contribution to the CT (objective), their personal contribution (subjective), and a blend of both.

Developing hypotheses about transference and countertransference processes

This step is the most demanding and the teaching and learning associated with this step constituted approximately half of the training time. Throughout this time, students took turns presenting examples of CT responses they had experienced towards a client, along with a description of the client's history of relationships, and the therapy situation. Having heard about the client's history of relationships, students were encouraged to think about the views of self and of others that a client holds. For example, some individuals may view themselves as inadequate and unable to solve their problems and view the therapist as someone who can make things better for them. Other clients with histories of mistreatment may feel distrustful of the therapist, view the therapist as someone in power that cannot be trusted, and avoid talking to the therapist about anything meaningful. These types of transferences come from the client's history of past relationships. Understanding these is helpful for student therapists and experienced therapists. It helps to understand the client and why they might be responding as they are. Thinking about the client's history of relationships and their views of self and other (or representations of self and other) can provide insight into the client's experiences and help the therapist remain empathic.

At this stage, the map provided by the Parent-Adult-Child (PAC) model (Berne, 1961) was introduced to students (See the Reflective Practice Guide for examples of using the PAC model). The PAC model is used to help students think about the client's transference reactions towards the therapist and the therapist's CT. The Child position represents a state in which a person

behaves, thinks and feel as s/he did in childhood; the Parent position is characterised by feelings, thoughts and behaviours learnt from parents or parent-figures; and the Adult engages in reality-testing and responds to the current circumstances without being triggered into a child or parental position. The Adult is also empathic towards others. Hence, in therapy situations, the therapist will aim to work in their Adult and to notice when they are triggered into a Parental or Child position. However, as noted in the Reflective Practice Guide, it is important to reflect on how you can be in your Adult in a way that is culturally appropriate.

Activity: Students took turns, sometimes in groups, to present their hypotheses about the therapist's CT (See the Four Page Guide for an example of using the PAC model). When this included a Māori student therapist working with a Māori client or a Pasifika student therapist working with a Pasifika client, the adaptation of the PAC model was discussed.

Managing the countertransference response

This step aimed to assist students to manage their own emotional-cognitive responses and to avoid CT behaviours. The first component involves students recognising when they had shifted into a child or parent position (PAC model) and consciously acknowledging this to themselves. Students were encouraged to use a calming or breathing technique as a way of managing their own responses during sessions when they notice this shift into a CT response. Participants were encouraged to consider the PAC model and to imagine coach themselves to move back into the Adult. It was acknowledged

that the shift back into the Adult might be more difficult to achieve with powerful CT responses, although repeated practice of this technique may increase its effectiveness.

Students were also encouraged to take an empathic position towards clients. Empathy appears to facilitate management of CT (Hayes et al., 2011). This could include self-talk in regard to the client's experiences; for example, "John has been through a really difficult time and it not used to talking openly to anyone. You can be patient and give him time to be more open about his situation".

Finally, it was noted that it might be more effective for students to initially practice reflecting on action before attempting to reflect in action (Schön, 1987). Students were encouraged to engage in both self-supervision after the session and also talk about their experience in clinical supervision. Reflecting on CT in action (Schön, 1987) may come with experience and practice.

Activity: Students were asked to think about the ways in which the therapist could manage his or her CT in the situations discussed and in some instances the words that the student therapist could say to himself to help him move back into an Adult position.

Method

Participants

Sixty-one clinical psychology students from 5 clinical psychology programmes completed the workshop. The size of the groups ranged between six and 13 students. Fifty-four (89%) participated in the evaluation. Students were given the opportunity to decline to provide demographics if they were concerned that this would identify them. This was particularly relevant for male participants. The age range and gender of one participant is unknown. Of the 53 participants who identified their gender, 46 (87%) were female and 7 (13%) were male. Twenty-four (45%) of the participants were in the modal age range of 25 to 29 years, and 13 (24.5%) were aged 30 to 34 years. Six (11%) were 20 to 24 years, and 10 (19%) were 35 years or older. Forty-one (77.5%) participants identified as New Zealand European; eight (15%) as Māori or Pasifika and four (7.5%) as Asian. Twenty-two (41%) participants were in their internship year (third and final post-graduate training year); 29 (54%) were in their second or third semester of working with clients; two (4%) were in their first semester; and one student reported having worked with clients for four years.

Five academic participants, one from each university, also took part in the study. One participant was a programme director, two were Psychology Clinic directors, and two were clinical educators. All participants were clinical psychologists. The participants had been in their current university roles between 1 and 10 years (*M*= 7.6 years). Two of the academic participants

from non-host universities are also authors (second and fourth) of the current paper.

Measures

Students' Anonymous Online Questionnaire. Participants completed an anonymous online questionnaire. The questionnaire contained open-ended questions. These included: Prior to doing the training, how often during sessions did you notice your CT responses, has this changed since doing the training in reflective practice and CT, and if so how? Has your understanding of CT changed as a result of the training and if so how? Please provide other comments or recommendations for change. Participants were then asked to rate six items on a 5-point scale to evaluate the training on a number of criteria related to the research questions (See Table 3 for the items).

Academics' Questionnaire. Academic participants were asked to complete a number of open-ended questions. These included: Please write about any positive benefits that you have observed students experiencing as a result of taking part in the training; What does the training add, if anything, to the professional development of students that was otherwise missing? Have you experienced any personal value from taking part in this training – either as a teacher, supervisor or therapist? Please write about any problematic or challenging aspects of the training or any areas that could be improved? Do you plan to continue on with this training or an adaptation of it in your programme and please comment on what issues impact decisions in this regard? What changes would you make to the training, if any?

Data analysis

The qualitative data from both the student and academic participants were analysed using the process of thematic analysis described by Braun and Clarke (2006). Two independent research assistants carried out the analyses of the qualitative data from the students' questionnaires. One was a post-doctoral researcher and the other a PhD student. The first and second authors also reviewed these. The data from the Academic participants were analysed by two academics that took part in the study, in discussion with the first author.

Results

Trainee Responses to Qualitative and Quantitative Questions

The results of three thematic analyses are presented below. These include: the analysis of data pertaining to changes in awareness and understanding of CT, and any other comments or recommended changes.

Changes in awareness and understanding of countertransference

Six (11%) participants reported they often noticed their CT reactions prior to the training, 45 (85%) reported occasionally or sometimes, and 2 (4%) never. Forty-nine (91%) participants reported that this had increased since the training. The remainder (9%) said this had not changed or that they had not worked with a client since the training. Six themes were defined pertaining to changes in awareness and understanding of CT (See Table 1). Quotes are provided in Table 1 to illustrate the themes.

In the first theme, *More aware of my countertransference reactions*, the majority of participants reported that they were now more "aware" or "conscious" of experiencing CT. The second, third and fourth themes all related to participants' observations of increases in their analysis and/or understanding of their CT reactions. In the second theme, *Analyze or reflect on countertransference*, participants wrote about reflecting more on their CT responses to clients, questioning themselves or their "motivations" more often, and thinking about the meaning of their CT reactions. In the third theme, *A better theoretical understanding,* participant statements related to having a better understanding of CT or of using the theoretical model of CT that was introduced in the training. Some said that they now understood that CT is "common", that their responses are "normal", and do not signify that something is wrong with them. In the fourth theme, *Countertransference and the therapeutic relationship,* participants indicated that reflecting on their CT experiences informed their understanding of what was happening within the therapeutic relationship. The fifth theme, *Can manage countertransference better,* focused on changes that participants had experienced in their ability to manage CT or included comments on positive benefits they observed in their practice. Finally, three participants wrote that their awareness or understanding had not changed, and two stated that they had not worked with a client since the training.

Table 1.

Participants' reports of changes in awareness and understanding of countertransference

Theme	*n* = 54	Example
More aware of my countertransference responses	49	Yes, I often notice them more now, even the subtle ones that don't cause a strong emotional reaction in me. I'm also better at noticing them in the moment rather than whilst reflecting on the session.
Reflect on or analyse countertransference	29	I find myself checking in with some frequency. What is going on here? Why am I thinking this etcetera? What is my motivation here? Where has this come from?
Countertransference and the therapeutic relationship	27	I now have a greater understanding of the philosophy, theory, and language of countertransference. This means that I can now communicate what I am experiencing in sessions, I have a greater understanding of why this is occurring, and how this affects both my client and I.
A better theoretical understanding	29	I didn't know a lot about countertransference before the course and had always found it difficult to grasp. I really appreciated that the course was practical and grounded within a CBT/psychodynamic framework as I could relate and incorporate this with what I already knew. From the course, I can conceptualise countertransference as being relational and happening in the room, as opposed to my previous preconception of it being far removed and theoretical.
Can manage countertransference better	17	Yes, I am now much more aware of countertransference situations when they arise, and am therefore able to make changes to my practice as I work.
No or have not worked with a client since the training	4	I haven't had a chance to see a client since the course in countertransference. No, not really.

Other comments and recommendations for change

Thirty-four participants responded to the question asking for further comments or recommendations for change (See Table 2). Twenty-six commented on positive aspects and 24 made recommendations for changes. The positive comments were placed together in the first theme. These often overlapped with previous comments and there were also some positive comments about the trainer's style. The second theme, *More time,* included comments about having more time for the training and for related activities. The third theme, *Clarifying concepts,* included comments about some confusion or the need for more clarity in regard to concepts taught in the training. The fourth theme, *More on managing countertransference*, related to the desire to have received more training in managing CT and some related this to having more time overall for the training.

Table 2.

Other Comments and Recommendations

Theme	*n* =34	Example
Positive comments	26	I think it's an integral part of training to be a clinical psychologist and it must absolutely remain a part of training for students.
More time	6	Because it's so complex and relatively new to me apart from bits and bobs I've read from textbooks, I felt like I needed to reflect on this more and a two-day course would probably be more helpful for me to grasp this concept more clearly.
Clarify concepts	4	Great training course, however the parent child and self model became confusing for me – otherwise great overall.
More on managing countertransference	10	Answering above did make me think that if we had more time, more practice examples could be given about how to manage countertransference.

Student evaluations of the Reflective Practice Guide

Participants were asked to rate the usefulness of the four-page Reflective Practice Guide using a 1 to 5 point scale (Not at all useful through to very useful). On average, participants rated the guide as useful (M = 4.14, SD = 0.92). Four themes emerged from the analysis of the qualitative data from the participants' comments about the guide (See Table 3).

Table 3.

Students' Evaluations of the Four Page Guide

Theme	n = 45	Example
Useful resource - helpful for guiding reflections or understanding concepts	34	I find this guide helps to break down something, which can seem complex and overwhelming into something that is more manageable.
Well designed, easy to follow, concise, good diagrams	11	It was clear, informative and easy to follow, and a great reference to refer back to. The graphic components were great. The final page is particularly helpful for ongoing reflection.
Have used it or plan to use it	16	This guide was concise, user-friendly and colourful which made me actually read over it. I keep a copy of the guide in my office and have referred to it several times when analysing countertransference responses.
Have not used it or have not seen clients yet	5	It is a useful resource but I have not used it as of yet.

The first theme, *A useful resource,* contained positive comments about ways in which the guide assisted students in the process of understanding CT. The second theme, *It's well designed,* included comments that the guide was easy to follow, provided clarity, and included useful diagrams. The third theme, *Have used it or plan to,* included comments that indicated participants had already used the guide or intended to in the future. Five participants wrote that they had not seen any clients since the training or had not used the guide yet although it seemed to them it would be useful.

Analysis of the quantitative results from the student questionnaire

Participants were asked to rate the training on a number of criteria using a 5-point scale (strongly disagree through to strongly agree) (See Table 4). The highest mean scores related to the training helping participants to understand the concept of CT (*M* = 4.69), for agreement with the idea that CT can provide insight into the client's experiences (*M* = 4.62), and for participants' increased commitment to monitoring their own CT (*M* = 4.61). The training was also highly rated for being useful for the participants' professional practice (*M* = 4.57), and overall satisfaction with the training was high (*M* = 4.51). The lowest rating was for the training providing ideas on how to manage CT (*M* = 3.89).

Table 4.

Student Participants' Evaluations of the Teaching and Learning

Items	Total Sample (*n* = 54) *M (SD)*
The training will be useful for my professional practice	4.57 (0.60)
The training helped me to understand the concept of countertransference	4.69 (0.47)
The training provided me with ideas about how to manage countertransference	3.89 (0.86)
I am committed to monitoring my own countertransference	4.61 (0.56)
Countertransference can provide insight into the client's experiences	4.62 (0.63)
Overall, I was satisfied with the training	4.51 (0.67)

Academics' Responses to Quantitative and Qualitative Questions

The themes from the analysis of the academic participants' responses are presented in Table 5. The first theme, *Provides a language and a framework*,

included comments about helpful aspects of the training, such as providing “a vocabulary”, a “scaffolding or framework”, and a “systematic way” to consider CT issues. The second, *Validates and increases awareness of emotional responses*, captures comments about how the training “gives legitimacy” to emotional experiences, encourages students to reflect on them, and seems to stimulate more awareness of feelings.

Table 5.

Academics Observations of Positive Effects of the Training

Theme	*n* =5	Example
Provides language and a framework for students experiences of countertransference	3	It gives a language, a framework and recognition of and around our reactions as therapists so that they do not remain invisible to us as therapists but can be used to enhance rather than limit therapeutic outcomes.
Validates and increases attention to and awareness of emotional responses	3	Being able to reflect and hypothesise on process issues happening in the relationship with a client moves students on to working with emotional states - theirs and the client's and trying to understand where these emotions emanate from. In doing so, the student moves to a deeper level of therapeutic understanding both with themselves and with the client.
Increases awareness of interpersonal processes	3	Increased awareness of what they, as therapists, bring to a therapeutic relationship and how their internal responses to a client can shape their behaviour.
Increased openness to or use of in supervision	3	I notice that students reflect on their own processes with open ease in both supervision as well as in other areas.

The third theme, *Increases awareness of interpersonal processes* expands this to the interaction between therapist and client, as most participants commented on how the training enhanced student awareness of "relational issues in therapy process," "process issues", and "complexities of the therapeutic relationship". The fourth theme, *Increases openness to supervision*, addressed how the training and the theoretical perspective affected the supervisory relationship, both bringing more open reflectiveness

on the part of the student, and also bringing increased complexities, as the supervision relationship expands to include not just cognitive but also affective learning.

Three academic participants commented on a challenge or concern they had in regard to the training. The first concern was about the impact of introducing CBT students to new and different models:

> Introducing other models, which have some subtle differences from CBT, may confuse them at this stage of their training. Having said that, I haven't seen any evidence to support my worry!

A second academic participant reported that students had difficulty with the notion of developing “hypotheses about their clients”. They still feel a need to 'get it right' or 'deal only with facts’. The third challenge or concern related to the extra demands and complexity that the training model brought with it to the supervisory relationship.

> The model requires being willing to explore and hold students’ issues more openly than training in a specific cognitive model. This can bring demands to supervision, which sometimes leans toward a more therapeutic relationship.

All participants reported that their programmes were planning to continue the training, or an adaptation of it, attributing this to “positive student feedback,” the “usefulness” and “importance” of the topic, and the “positive impact” for students and clients. There was one suggestion for change to the training to include “real therapy transcripts illustrating the concepts” taught in the workshop.

Table 6.

Mean Scores and Standard Deviations for Academics' Evaluations of the Training

Item	Mean score	SD
I am pleased that our students took part in this training	4.80	0.45

Academic participants' quantitative evaluations of the training

The academic participants reported that they were pleased with taking part in the training (*M* = 4.8) (See Table 6) and hoped to continue to offer the training or an adaptation of it in their programmes (*M* = 4.80). They reported observing an increase in trainees' awareness of CT (*M*= 4.2) and a better understanding of CT (*M*= 4.2).

(n = 5)		
I observed an increase in awareness of countertransference with students I worked with following the training (*n* = 5)	4.20	0.45
I observed a better understanding of countertransference with students I worked with following the training (*n* = 5)	4.20	0.84
I observed a decrease in countertransference behaviors in sessions with students I worked with following the training (*n* = 4)	3.25	1.26
I recommend this training, or an adaptation of it, to other programmes (*n* = 5)	4.40	0.55
I hope to continue offering this training, or an adaptation of it, in our programme (*n* = 5)	4.80	0.45

There was a lower level of agreement, however, with observing a decrease in trainees' CT behaviors following the training (*M*= 3.25). This may have reflected the lack of measurement of changes in CT behaviour – which was beyond the scope of this study.

Conclusions

The results of the study are promising. As discussed earlier, there is evidence that therapists who are more aware of their CT feelings *and* have a theoretical framework for understanding these feelings will engage in less CT behavior (Latts & Gelso, 1995; Robbins & Jolkovsky, 1987). The majority of students in the current study reported increased awareness of CT in their therapy sessions. Similarly, the academic participants reported observing an increase in students' awareness of CT accompanied by more openness to talking about CT and reflecting on CT in supervision or in classroom situations. The majority of students also indicated through their written statements and ratings that their understanding of CT had increased as a result of the training. They reported

they found it helpful to have the theoretical model and its associated language to help them make sense of and communicate about their CT experiences. Academic participants made similar observations. They noted that students now had a language for talking about CT, and a framework or "scaffolding" to help them to make sense of these experiences.

Given that awareness of CT combined with the ability to conceptualize CT may facilitate CT management, we could expect that the teaching and learning approach may have facilitation students' CT management. Some students wrote about their increased confidence in managing CT, and their ratings of the training's provision of ideas about how to manage CT were moderately high although lower than ratings for the other items. These moderate ratings may reflect an increase in students' confidence in managing CT but also some cautiousness in this regard, which is appropriate for their level of experience. The report of moderate learning in regard to managing CT may also reflect a useful beginning to the process of learning to understand and manage CT, which is challenging even for the most experienced therapists.

Finally, it is important to comment on the students' responses to the Reflective Practice Guide that was developed for the study. The guide was given to students ahead of the training to introduce them to the new concepts. However, some said they had not used it yet or planned to use it in the future. The majority of students who did report on using the guide said that it was helpful or very helpful.

Students were also encouraged to use the template for reflective practice that is part of the guide. However, students' evaluations of the training and of the

Reflective Practice Guide were collected two to three weeks after the training and this may not have allowed time for sufficient practice. A future study could examine the impact of the template on students' reflective practice and their ability to understand and manage CT. It is likely, however, that the guide will be most useful to students if clinical supervisors encourage them to use it and provide feedback on it. This was beyond the scope of the current study.

It is important to consider the limitations of the study. The study extended the teaching approach to CT into clinical psychology programmes in Aotearoa New Zealand that do not offer training in CT. The data collection method used in this study was appropriate for the university programmes and for the participatory nature of the study. However, the study relies on trainees' self reports and the observations and self-reports of participating academics. Further, the trainee data was collected approximately three weeks after the training was completed. This gap was designed to allow trainees to reflect on the training before evaluating it. However, this is still a relatively small amount of time for trainees to translate what they learnt into practice. It seems likely that trainees would take more time to trial different strategies and may still be doing so.

In conclusion, five university clinical psychology programmes took part in this study of a teaching and learning approach to understanding and managing CT. The majority of students responded well to the teaching approach and reported that it increased their awareness and understanding of CT along with some increased confidence in managing CT. Academic staff also observed an increased openness to talking about CT, accompanied by a framework for

understanding CT. All of the programmes reported that they would like to continue offering the teaching, or an adaptation of it, in their programmes.

It is also important to note that this teaching and learning approach to understanding and managing CT is likely to be relevant to other professional groups including teachers, doctors, nurses, physiotherapists, massage therapists and others who work in the helping professions. Future research could examine ways in which the current teaching approach could be adapted for training in other professions.

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