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Practitioner Countertransference and Evaluation

of Callous and Unemotional Trait Clients

by

Frances K. Braun

B.A., Middlebury College, 1991
M.S., Antioch University New England, 1994
M.S., Antioch University New England, 2011

DISSERTATION

Submitted in partial fulfillment of the requirements for the degree
of Doctor of Psychology in the Department of Clinical Psychology
of Antioch University New England, 2013

Keene, New Hampshire

Department of Clinical Psychology

DISSERTATION COMMITTEE PAGE

The undersigned have examined the dissertation entitled:

PRACTITIONER COUNTERTRANSFERENCE AND EVALUATION OF CALLOUS AND UNEMOTIONAL TRAIT CLIENTS

presented on March 20, 2013

by

Frances "Cricket" Keleher Braun

Candidate for the degree of Doctor of Psychology
and hereby certify that it is accepted*.

Dissertation Committee Chairperson:
Kathi A. Borden

Dissertation Committee members:
Timothy Stickle, PhD
Barbara Belcher-Timme, PsyD

Accepted by the
Department of Clinical Psychology Chairperson

Kathi A. Borden, PhD

on **3/20/13**

***** Signatures are on file with the Registrar's Office at Antioch University New England.

Dedication

To John, my husband, for your encouragement, humor, friendship, and gourmet spaghetti dinners, and my children: Cally, Tatum, Walter, and William for your playfulness, joy, and getting through years of Monday night mayhem. And to my parents, Wendy and Terry Keleher, for investing in my education, teaching me about "fiber and grit," and instilling in me the confidence I needed to get through this process.

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Abstract

This on-line study evaluated whether the presence of callous and unemotional (CU) traits in a written case description affects practitioners' countertransference (CT), appraisal of both global and specific client traits and other therapy-relevant variables. One hundred and fifty three mental health practitioners were randomly assigned to one of two groups: One group read a hypothetical case description of a client who did not present with CU traits (NCU Group) while the other group read the same case description as the NCU Group, but with the addition of CU traits (CU Group). The results demonstrated that the presence of CU traits not only was related to CT, but also to how much time and energy practitioners invested in treatment, their likelihood of referral, and their anticipated therapy effectiveness. Consistent with the halo effect, the global assessment of CU traits, and likability was also related to practitioners' assessment of a more specific client trait. Last, practitioners indicated that the "likability" of likable clients had more influence on their assessment of clients and ratings of therapy-relevant variables than the "likability" of unlikable clients. Although practitioners who work with CU trait clients strive to effect change and reduce problematic behavior, they are confronted with the formidable task of forging an alliance with clients who are typically unresponsive to and disengaged from treatment. It is hoped that this study will prompt practitioners to examine and learn from their emotional responses to these difficult clients and expand their knowledge of CU trait clients so that they might better understand CU trait clients' suffering, cultivate empathy, and effectively treat their pain.

Keywords: callous, unemotional, countertransference, likability, halo effect, psychopathy

Chapter 1

> Man wishes to be confirmed in his being by man, and wishes to have a presence in the being of the other... Secretly and bashfully he watches for a YES which allows him to be and which can come to him only from one human person to another. (Buber, 1951, p. 111)

Practitioners who work with adolescents high in callous and unemotional (CU) traits are placed in an unenviable position. On the one hand, they may strive to cultivate a therapeutic alliance and effect change to reduce the risk of future problematic behavior. Yet research consistently demonstrates that high CU trait individuals not only are resistant to treatment, but also comprise a subgroup of antisocial youth who exhibit high levels of aggressive and antisocial behavior across a variety of settings (Caputo, Frick, & Brodsky, 1999; Christian, Frick, Hill, Tyler, & Fraser, 1997; Frick, Cornell, Barry, Bodin, & Dane, 2003; Frick & Ellis, 1999). CU trait individuals lack empathy, guilt, and emotional responsivity (Patrick, 2007). Thus, practitioners are confronted with the formidable task of not only of forging an alliance with youth who are typically indifferent to and disengaged from treatment, but also implementing interventions that have demonstrated ineffectiveness (Hawes & Dadds, 2005). As a result, practitioners who work with CU trait adolescents are vulnerable to negative emotional responses to and negative global appraisals of clients who present with CU traits. Awareness of these responses and influence of such appraisals could not only promote insight into the counseling relationship (Singer & Luborsky, 1977), but also minimize negative therapeutic behavior that accompanies unexamined emotional responses (Gelso & Hayes, 1998).

The Challenges of Working with CU Trait Clients

Since the requisite affective bond between client and practitioner and commitment by each party to goals of treatment may be perceived as untenable, establishing a working alliance with challenging clients is indeed daunting (Horvath, 2001). Further, the cumulative result of the above listed CU characteristics may contribute to the three dimensions of clinician burnout established by Maslach & Jackson (1981): emotional exhaustion, depersonalization, and a reduced sense of accomplishment. This constellation of burnout symptoms can lead to a decreased quality of service and lower job performance (Garner, Knight, & Simpson, 2007; Maslach & Jackson, 1981). In an attempt to avoid burnout, and without known tools to effect change, practitioners may negatively appraise CU trait adolescents and-or rightly conserve energy and resources, choosing instead to focus on clients where their efforts are more promising and rewarding. Although rationing resources may indeed be an effective strategy for preventing clinician burnout, and thus provide overall superior care to the practitioner’s clients, individual recipients of conscious or unconscious truncated care certainly are less likely to benefit from treatment than those who have a typical therapeutic experience.

Thus, in addition to the distinct cognitive, emotional, biological, and personality characteristics that affect treatment outcome, practitioner countertransference (CT), as reflected in their primary client appraisal (Fauth, 2006), to high CU trait clients could impact the working alliance, likelihood of referral, investment in treatment, and ultimately amplify the poor outcomes and high rate of recidivism demonstrated among high CU trait adolescents. Although effective treatment options for high CU trait youth have not been clearly established, the presence of CU traits may trigger practitioner CT, and thus eclipse the warmth and empathy necessary to facilitate change. Importantly, prioritization of and attention to practitioner CT

could at the very least minimize what appears to be a doomed outcome and alert practitioners to their increased vulnerability to negative therapist attitudes and behavior. Finally, since client likability not only is identified as a variable impacting therapeutic outcome (Stoler, 1963), understanding client likability's potential contribution to the halo effect (where global evaluation of others can unconsciously alter the evaluation of specific attributes; Nisbett & Wilson, 1977b) warrants investigation. In sum, practitioners' CT to and negative global evaluation of CU trait clients is a potential liability for working with this population; attention to CT and the influence of unconscious mechanisms that influence outcomes and judgment could be leveraged as a much needed tool in what currently is an impotent practitioner toolkit for this population.

Stakeholders

CU traits have emerged among other dimensions of psychopathy (i.e., impulsivity and narcissism) in identifying a distinct, more aggressive and violent subgroup of antisocial youth (Frick & Moffit, 2010; Patrick, 2007). Despite substantial efforts and resources dedicated to rehabilitating these youth, high CU trait individuals' risk of recidivism and conduct disordered behavior persists. As a result, taxpayers, mental health agencies, families of CU trait youth, and caregivers who work with these youth endure a significant financial and emotional burden. Attending to variables that contribute to or exacerbate poor outcomes, such as practitioner CT in response to CU trait clients or client likability, could not only result in initiatives aimed at improving practitioner performance, but also ensure CU trait youth receive quality care. Additionally, since symptoms of burnout could negatively impact coworkers, clients, and organizations, minimizing and identifying these risks is prudent not only to improve outcomes, but also to maximize employee and organizational effectiveness and reach of limited resources (Garland, 2002).

Although measures such as the Inventory for Callous and Unemotional Traits (ICU; Frick, 2004, as cited in Kimonis et al., 2008), the Hare Psychopathy Checklist: Youth Version (PCL-YV; Forth, Kosson, & Hare, 2004) and the Antisocial Process Screening Device (APSD; Frick & Hare, 2001) are used to assess CU traits, without effective interventions these measures only serve to identify difficult and treatment resistant patients. Although Henry Richards argues "thanks to the tools like the PCL-R [the Hare Psychopathy Checklist-Revised], instead of wasting limited resources on a few bad apples, the justice system can focus those resources on the majority of offenders – those who can profit from a second chance and are, more often than not, motivated to change" (Richards, 2012, p. 2), simply identifying a "bad seed" not only risks reifying the stigma associated with this population, but may result in distorted judgments about CU trait clients and prompt practitioner indifference or helplessness since effective interventions with this population have not been clearly established. However, practitioners committed to self-reflection might find hope and empowerment in understanding how their appraisal of high CU trait individuals impacts CT and treatment and potentially contributes to the behavioral and personality sequelae of high CU trait individuals.

Chapter 2: Literature Review

Introduction and Conceptual Framework

Although a variety of mechanisms have been proposed to explain the high recidivism rate, resistance to treatment, and increase in violent and aggressive behavior in CU trait individuals, practitioner CT to this population and the influence of practitioners' global evaluations has not been explored. Specifically, abnormalities in responsiveness to punishment cues (Frick et al., 2003; Hawes & Dadds, 2005), diminished responsiveness to distress cues in others (Woodworth & Waschbusch, 2008), inability to take the perspective of others (Anastassiou-Hadjicharalambos & Warden, 2007), and reduced amygdala response to fearful expressions (Dadds & Salmon, 2003; Fowles & Kochanska, 2000; Jones, Laurens, Herba, Barker, & Viding, 2009; Marsh et al., 2008) have all been demonstrated in CU trait individuals. Although these characteristics are central to the poor outcomes for these youth, practitioner CT to CU client characteristics and the influence of practitioner global evaluations as measured by client likability remains poorly understood.

Since a working alliance is requisite for effective treatment (Bordin, 1979; Safran & Muran, 2000; Summers & Barber, 2003) variables that threaten its establishment, notably CT (Gelso & Hayes, 2002; Najavits et al., 1995) and client likability (Stoler, 1963), are worth exploring. Consistent with Fauth and Hayes's (2006) definition of CT as a "stressful interpersonal event in which the therapist appraises the counseling situation as harmful to, threatening, challenging, and/or taxing of her or his coping resources" (p. 431), this study explores whether or not the written presentation of CU traits evokes practitioner CT. Similarly, and consistent with Nisbett and Wilson's (1977b) assertion that global evaluations of a person influence other specific judgments about their specific traits, whether or not the presence of CU

traits influences practitioners' global evaluation of clients (as measured by likability) and in turn alters their evaluation of both ambiguous and unambiguous client variables and information is worth examining. Thus, measuring whether or not the addition of CU traits in a case description of an adolescent affects therapists' CT, evaluation of likability and other client traits, likelihood of referral, investment in treatment, and anticipated therapy effectiveness was investigated. This study also evaluated whether or not knowledge of CU trait literature and level of exposure to CU trait clients were related to CT, treatment investment, likelihood of referral, anticipated therapy effectiveness, and client likability. Last, practitioners' awareness of the influence of likability on their ratings of specific client traits and anticipated therapy effectiveness was explored.

What are CU Traits?

Adolescents who exhibit the following characteristics either by self-report or as reported by others, would meet the proposed Conduct Disorder specifier, callous and unemotional traits, for the upcoming fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; Frick & Moffitt, 2010; Scheepers, Buitelaar, & Matthys, 2011): *lack of remorse or guilt, callous-lack of empathy, unconcerned about performance,* and *shallow or deficient affect*. Although CU trait adolescents may express remorse when caught or facing punishment, typically, adolescents who exhibit *lack of remorse or guilt* don't experience feelings of guilt or remorse when they do something wrong (Scheepers et al., 2011). Further, CU trait adolescents are indifferent to the feelings of others (*callous-lack of empathy)* and are unconcerned about poor school or work performance (*unconcerned about performance).* Last, CU trait adolescents are able to quickly turn their emotions on and off, particularly as a means to manipulate or intimidate others. This *shallow or deficient affect* characteristic is also demonstrated in their general tendency to not express emotions or feelings at all.

Assessing Callous and Unemotional Traits

Because CU traits represent one of the three personality dimensions of psychopathy (the other two being narcissism and impulsivity), measures used to assess psychopathy such as the Hare Psychopathy Checklist: Youth Version (PCL-YV; Forth et al., 2004) and the Antisocial Process Screening Device (APSD; Frick & Hare, 2001) are sometimes used to assess CU traits. In an effort to overcome the psychometric limitations of using the above measures to assess CU traits (see Kimonis et al., 2008 for a review), Frick (2004, as cited in Kimonis et al., 2008) developed the Inventory of Callous-Unemotional Traits (ICU) to assess the three factors in CU traits: uncaring, callous, and unemotional (Kimonis et al., 2008). Since the CU dimension, but not other dimensions of psychopathy (impulsivity, narcissism), differentiates youth within antisocial youth and youths with conduct disorder, Frick and Moffit's (2010) proposed specifier "With Significant Callous-Unemotional Traits" will be added to the diagnosis of Conduct Disorder in the upcoming edition of the Diagnostic and Statistical Manual for Mental Disorders set to be published in May, 2013 (American Psychiatric Association, 2012).

Concerns about Labeling

Although there is no research on the effects of the label "callous and unemotional," the "damning" (Edens, Skeem, Cruise, & Cauffman, 2001, p. 76) effects of the term "psychopathy" has been emphasized by scholars (Hare, 1998; Vincent & Hart, 2002). For example, when undergraduate mock jurors read a written description of an adult defendant in which the diagnostic label (psychopath, psychosis, or no label) was manipulated, participants rated the psychopathic defendant as posing more risk of violence than the defendant with no diagnosis (Edens, Desforges, Fernandez, & Palac, 2004). However, in a study that examined the influence of diagnostic criteria and labels for psychopathy or conduct disorder on judicial decisions,

Murrie, Boccaccini, McCoy and Cornell (2007) demonstrated that juvenile court judges not only weren't responsive to psychopathy labeling, but also were more likely to recommend psychological treatment to juveniles who demonstrated psychopathic traits and were labeled psychopathic.

Other researchers recommend using caution when interpreting assessment tools such as the Hare Psychopathy Checklist-Revised (PCL-R), the gold standard for assessing "psychopaths" (and callous and unemotional traits), because they are vulnerable to human bias and cultural influences. Karen Franklin (2012), in response to a piece on National Public Radio's show *All Things Considered* (Spiegel, 2011), "Can a Test Really Tell Who's a Psychopath?" outlined the history of some criminal psychopaths. She explained how crime as rooted in biological degeneracy was adopted by the white supremacist eugenics movement of the early 20th century and how by the late 20th century, the media's portrayal of hard-wired psychopaths "helped cement the psychopath as a cultural icon" (Franklin, 2012). She goes on to argue that by

> foregrounding intrinsic evil, psychopathy marginalizes social problems and excuses institutional failures at rehabilitation. We need not understand a criminal's troubled past or environmental influences. We need not reach out a hand to help him along a pathway to redemption. The psychopath is irredeemable, a dangerous outsider who must be contained or banished. Circular in its reasoning, psychopathy is nonetheless alluring in its simplicity. (p. 1)

Others (Edens, 2012; Skeem, Douglas, & Lilienfeld, 2009) concur that using terms such as "psychopath" is stigmatizing and risks "evoking images of fictional villains like Hannibal Lecter as well as real-world serial killers such as Ted Bundy and Jeffrey Dahmer. Calling someone a remorseless, callous psychopath can have a profound impact on how that person is viewed by

others, such as members of a jury or a parole board" (Edens, p. 2). Further, Edens asserts not only that the PCL-R scores that examiners give clients are inconsistent, but also that the personality component of the PCL-R relies too much on subjective judgment and is thus vulnerable to error. Although assessment tools can identify individuals who possess psychopathic traits, clinicians should not only use clinical judgment and collateral sources to validate assessments, but also understand the subjective nature of these assessments and how labeling potentially impacts decisions made about client treatment and care.

Why CU Traits in Adolescents?

Among adults, psychopathic traits have been implicated in severe and chronic patterns of antisocial behavior that are particularly violent, resistant to treatment (Frick & Moffitt, 2010; Patrick, 2007; Serin, Peters, & Barbaree, 1990), and distinct from those of nonpsychopathic individuals (Blair, Peschardt, Budhanir, Mitchell, & Pine, 2006; Lykken, 1995; Patrick, 2007). Three dimensions consistently emerge in most descriptions of adult psychopathy (Hare, 1993; Cleckley, 1988): (a) CU traits, often described as lack of affect; (b) a narcissistic view of oneself, arrogance, and manipulative behavior; and (c) impulsivity, irresponsible behavior and susceptibility to boredom. Because several longitudinal studies indicate that adult antisocial behavior begins in childhood (as summarized in Loeber, 1982), the concept of psychopathy has been extended to children and adolescents. Further, the dimensions of adult psychopathy (CU traits, narcissism, and impulsivity) have been identified in incarcerated (Neumann, Kosson, Forth & Hare, 2006) and pre-adolescent children (Frick, Bodin, & Barry, 2000).

In both adult and youth antisocial populations, CU traits are associated with elevated psychopathic traits (Barry et al., 2000; Caputo, Frick, & Brodsky, 1999; Cleckley, 1988; Cooke & Michie, 1997; McMahon, Witkiewitz, & Kotler, 2010). Specifically, CU traits are higher than

other dimensions of psychopathy in violent sex offenders compared to other offenders (Cooke & Michie, 1997) and are associated with poor prognosis on five of six antisocial outcomes (McMahon et al., 2010). In fact, McMahon et al. contended that CU traits had superior predictive validity over other established predictors of antisocial outcomes (Oppositional Defiant Disorder, Conduct Disorder, and Attention Deficit and Hyperactivity Disorder).

Additionally, in samples of both clinic-referred (Frick et al., 2000; Frick, O'Brien, Wootton, & McBurnett, 1994) and non-referred (Frick et al., 2000) children, the CU dimension emerged from the other two dimensions of psychopathy (impulsivity and narcissism) and distinguished a subgroup of youth who demonstrated early-onset disruptive behavior disorder, providing support that CU traits identify a subgroup within antisocial youth that is useful to distinguish from other antisocial individuals. Further, although conduct disorder behavior and CU traits covary, these two constructs can be reliably distinguished using parent reports in preschool aged children (Dadds, Fraser, Frost, & Hayes, 2005). Specifically, Hawes and Dadds (2005; 2007) demonstrated not only that 4- to 8- year old boys diagnosed with Oppositional Defiant Disorder whose parents were referred to a parent training program had poorer outcomes if they were high in CU traits, but also that boys with the highest and most stable CU traits exhibited the least improvement in general conduct problems at 6-month follow-up. Similarly, Frick, Stickle, Dandreaux, Farrell, and Kimonis (2005) found that among 98 children selected from a school community screening, conduct disordered children who also exhibited CU traits had more police contact, higher rates of conduct problems and self-reported delinquency across their four yearly screenings. Burke, Loeber, and Rahey (2007) and Lynam, Caspi, Moffitt, Loeber, and Stouthamer-Loeber (2007) showed that the presence of CU traits in childhood are significantly related to measures of psychopathy in adulthood, even when controlling for

childhood conduct problems and other risk factors for antisocial behavior. Given the accumulating evidence that CU traits are present at a young age, strategies oriented toward early intervention and prevention are now being explored (Hawes & Dadds, 2005; Hawes & Dadds, 2007; Pasalich, Dadds, Hawes, & Brennan, 2011).

The Stability of CU Traits

Frick and Dantagnan (2005) and Frick and White (2008) addressed the issue of whether or not the behaviors that define CU traits are stable enough to be deemed a trait. From their review of the literature, Frick and White concluded that a number of studies indicate stability of these traits throughout development, justifying the term "trait." Based on parent and teacher reports of "interpersonal callousness," Obradovic, Pardini, Long and Loeber (2007) annually assessed 506 inner-city boys from ages 8 to 16. Their results supported the unidimensionality of what they termed an interpersonal callousness construct, and revealed stability of interpersonal callousness along their nine years of assessment. Additionally, self-report measures (Munoz & Frick, 2007) suggested that CU traits are stable from late childhood to adolescence. Similarly, other research (Blonigen, Hicks, Kruger, Patrick, & Iacono, 2006; Burke et al., 2007; Lynam et al., 2007; McMahon et al., 2010) indicated that the CU dimension is relatively constant from late adolescence into early adulthood and supports the utility of using the presence of CU traits as a predictor for adult psychopathy. Regarding younger children, moderate 1-year stability estimates (r = .55) for parent-reported CU traits were found in a community sample of Australian children who were 4 to 9 years of age (Dadds et al., 2005).

Seeds of Hope

Despite the stability of CU traits, recent research (Frick et al., 2003; Hawes & Dadds, 2007; Lynam et al., 2007) suggests that although these traits may indeed be stable, they

nonetheless are susceptible to change. Guided by the principle that change is greatest early in life, Hawes and Dadds (2005; 2007) report some malleability of CU traits among a group of young boys whose parents received a parent-training intervention. Further, Pardini, Lochman, and Powell (2007) showed that although CU traits are moderately stable and predictive of antisocial behavior, children exposed to less physical punishment and more parental warmth showed decreases in CU traits over time. In their study that examined the treatment progress of 86 delinquent boys, Caldwell, McCormick, Umstead and Van Rybroek (2007) demonstrated that youths with psychopathic features (as measured by the Hare Psychopathy Checklist: Youth Version) not only benefitted from treatment but also showed that psychopathic features were not predictive of poor treatment response or recidivism after treatment.

Contrary to the assumption that psychopathic individuals are recalcitrant to treatment, Salekin's (2002) review of 42 treatment studies on psychopathy revealed that intensive, long-term individual therapy (both cognitive-behavioral and psychoanalytic) were beneficial (increase in remorse and empathy was noted). Additionally, group therapy and treatment programs that include family members enhance overall treatment effectiveness (Salekin, 2002). Therefore, it is plausible that although CU traits may be relatively stable, they also "appear to be at least somewhat malleable and seem to be influenced by factors in the child's psychosocial environment" (Frick & White, 2008, p. 361).

Although Cleckley (1988) asserted that for psychopaths "wholehearted anger, true or consistent indignation, honest solid grief, sustaining pride, deep joy, and genuine despair are reactions not likely to be found" (p. 348), Gullhaugen and Nøttestad (2011) through their review of 11 cases using object relations theory, contested this assertion and concluded that severely psychopathic offenders do indeed suffer psychological pain. Further, although practitioners

typically assume psychopathy (of which CU traits is one dimension) is hard-wired, stable, and untreatable, Gullhaugen and Nøttestad reported not only that psychopathic individuals typically come from a background of physical and-or psychological abuse, but also that these individuals are likely vested in presenting in a callous and unemotional way. Gullhaugen and Nøttestad explain that psychopathic individuals often have been exposed to extreme parenting styles (either neglectful or overly-controlling) and that their behavior is thus related to their life experiences. In short, these researchers asserted that for psychopaths, biology and environment influence each other and that the psychopaths' relational vulnerability is part of their personality disorder.

When Helping Isn't Helping

Despite these new and promising findings, practitioners who work with CU trait clients are still confronted with the grim reality that their clients will reoffend, be indifferent to treatment, and become more violent and aggressive. As a result, practitioners with frequent exposure to these clients not only approach them from a pessimistic stance, but also are likely to experience the cardinal emotional exhaustion, depersonalization, and reduced sense of accomplishment associated with job burnout (Gullhaugen & Nøttestad, 2011; Maslach & Jackson, 1981; Maslach, Schaufeli, & Leiter, 2001; Salekin, 2002). Since practitioners who work with high CU trait clients often are overextended and fatigued, they are more likely to depersonalize their clients; by maintaining a distance between oneself and the client, work demands are more manageable because clients are considered impersonal objects of one's work (Maslach, Schaufeli, & Leiter, 2001). However, the cost of chronic exhaustion and resultant depersonalization is steep: not only do both interfere with practitioner effectiveness, but also their sense of accomplishment (Maslach et al., 2001). Last, practitioners who work with CU trait clients often confront a perennial sense of helplessness and failure. This tripartite of risk factors

increases the chance for practitioner burnout and inevitable challenges of treatment delivery (Maslach & Jackson, 1981; Maslach et al., 2001).

Why Does Countertransference Matter?

Despite the emphasis on CT in clinical settings, relatively few studies have committed to exploring this dynamic. However, as evidence mounts that therapist variables such as the therapist's personality and ability to cultivate a relationship contribute more to outcome variance than do patient variables or theoretical orientation (Luborsky et al., 1986; Najavits & Strupp, 1994; Wampold, 2001), research targeting more nebulous therapist attributes such as attitudes, emotions and CT is now emerging. Of relevance, this research suggests that even a small amount of negativity in therapists' reaction to clients impedes treatment (Henry, Schacht, & Strupp, 1990). In fact, Strupp (1993) found that therapists' immediate negative attitudes toward the patient were associated with loss of empathy and negative clinical judgments and contribute to a grim and self-fulfilling prophecy. Further, effective management of CT reactions results in better alliances, outcomes, and deeper sessions with clients (Gelso, Fassinger, Gomes, & Lattes, 2002; Gelso & Hayes, 2002; Singer & Lubrosky, 1977; Strupp, 1980). Last and importantly, therapists' self-reported emotions were related to their rating of the helping alliance (Najavits et al., 1995), a known and often cited predictor of outcome (Bordin, 1979; Safran & Muran, 2000).

Consistent with the Lazarus and Folkman (1984) and Fauth and Hayes (2006) conceptualization of CT, practitioners' primary appraisals, or evaluations of stressful events, is a means of gauging CT. From this stance, CT results when practitioners appraise the counseling situation as "harmful, threatening, challenging, and/or taxing of her or his coping resources" (Fauth & Hayes, 2006, p. 14). Coping strategies intended to minimize potential client demands, then, are thought to reflect CT. Lazarus and Folkman assert that cognitive appraisal is a

subjective process that identifies psychological stress that harms, threatens or challenges one's sense of well-being. While *Harm* indicates damage or loss that has already occurred and *Threat* suggests the potential of damage or loss, *Challenge*, recognize s therapists' positive emotions in response to their client, and reflects the therapists' optimism that therapeutic obstacles are surmountable. Contrary to classical definitions of CT that view CT as a manifestation of the therapist's unconscious, repressed, and regressive conflicts (Freud 1910/1957), contemporary theorists acknowledge both positive and negative CT and assert that CT is expected and often reflects the client's interpersonal dynamics (Levenson, 1995).

Why Would Practitioners React Negatively to CU Traits?

The defining characteristics of high CU trait individuals pose significant challenges to practitioners intent on kindling connection. In addition to practitioner reaction to CU trait clients' sometimes abhorrent offenses, warranted concern about clients' motivation to change, noncompliance and the notion that psychopaths don't suffer are significant barriers to establishing a therapeutic alliance (Cleckley, 1988; Gullhaugen & Nøttestad, 2011). Additionally, summoning empathy, a known change agent in therapy (Rogers, 1951), for clients who consistently display little affect or concern for others presents yet another hurdle, particularly since emotional intensity is what draws many into the helping profession (Najavits, 2000). In fact, in response to the mental health community's pessimistic stance on treatment with these clients, many clinicians have "abandoned the curative treatment model" (Gullhaugen & Nøttestad, p. 351).

Forays into alliance building that are met with indifference, disregard and defiance are likely to result in practitioner frustration, feelings of hopelessness and lack of confidence. Thus, in an effort to conserve energy and prevent burnout, practitioners might invest less in high CU

trait clients than others, since experience with this population and knowledge of the literature both suggest that their attempts at alliance building and change are often made in vain (Patrick, 2007). Last, since intense patient emotions are related to intense therapist emotions (Imhof, 1991), therapist vulnerability to projective identification is at the very least compelling.

Knowledge Isn't Power

Just as reading about a character in a novel evokes emotions in the reader, so too did Brody and Farber (1996) discover after reading written vignettes, certain client diagnoses were related to therapist emotions. Specifically, while borderline clients evoked the most anger and the least liking, empathy, and nurturance, depressed clients evoked positive feelings. Although the exact cognitive processes that account for these emotional responses to client diagnoses may not be accessible, they nonetheless influence judgment (Nisbett & Wilson, 1977a, b). Since nonverbal, interpersonal variables cannot account for Brody and Farber's results, potent prior knowledge of these diagnoses (stimuli) may have justified an emotional response without even experiencing the client in person, thus initiating a self-fulfilling prophecy. Additionally, although psychopathy, of which callous and emotional traits is an identified dimension, has inspired the development and use of numerous measures, submitting to the pervasive lore that psychopathy is untreatable negates the utility of such assessment tools (Salekin, 2002).

The Halo Effect and Client Likability

Originally named by Thorndike (1920), the halo effect is a social psychology phenomenon whereby global evaluations of a person's attributes significantly impact evaluations of their specific attributes. This phenomenon suggests that both ambiguous and unambiguous traits are colored by one's global evaluation. For example, the set of behaviors associated with the descriptor "impulsive" (ambiguous trait) for a person who is globally assessed as playful and

friendly will likely be quite different from those of a person who is globally assessed as angry and controlling. The ~~Halo~~ halo effect, however, is also capable of distorting perceptions of unambiguous stimuli, as well. This explains why male college students rated essays written by women who were allegedly attractive significantly higher than essays written by women who were allegedly unattractive (Landy & Sigall, 1974).

Nisbett and Wilson (1977b) argued that "people have little awareness of the nature or even the existence of cognitive processes that mediate judgments, inferences, and the production of complex social behavior and that the halo effect would appear particularly likely to be such a subterranean unrecognized process" (p. 251). In order to test whether or not the distorting influence of the halo effect indeed resides outside the realm of conscious awareness, Nisbett and Wilson (1977b) showed two videotapes of a college instructor, one where he was warm and friendly, in the other, cold and distant, to 118 college students. Subjects who viewed the warm instructor video rated his appearance, mannerisms, and accent as appealing whereas those who saw the cold instructor video rated his attributes as irritating. Additionally, the subjects who saw the cold instructor video believed that their global rating of the instructor (dislike) had no effect on their rating of his attributes, but only influenced their global evaluation. These findings support Nisbett and Wilson's earlier argument (1977a) that even though we assume we accurately assess attributes of others, our judgments are unconsciously altered by our global evaluations.

Consistent with Stoler's (1963) findings that client likability can be reliably rated and is possibly related to success in therapy, client likability may not only be a mediating variable influencing the poor outcomes of high CU trait clients, but the global evaluation of whether or not a client is likable or unlikable might unknowingly influence outcomes as well. Thus,

investigating the potential influence of the halo effect on practitioners' global and specific appraisals of CU trait clients might offer surprising insight into therapeutic work with high CU trait clients. Additionally, I submit that case descriptions that include CU traits, trigger CT, and risk reifying a potential CU construct and shaping anticipated poor outcomes for high CU trait clients.

Research Questions

The following research questions were investigated for this study:

1. Does the presence of CU traits, in an otherwise similar case description, affect CT, as measured by practitioners' primary appraisal?
2. Does the presence of CU traits, in an otherwise similar case description, affect practitioners' treatment investment, likelihood of referral or anticipated therapy effectiveness?
3. Is there a relationship between practitioner knowledge of and experience with CU trait clients and CT as measured by practitioners' primary appraisal?
4. Is there a relationship between practitioner knowledge about and experience with CU trait clients and practitioners' investment in treatment, likelihood of referral, anticipated therapy effectiveness, client likability, and evaluation of trait information (practitioner assessment of client appearance, practitioner assessment of client intelligence, and definition of self-confident as it applies to the client in their case description)?
5. Are high CU trait clients less likable than clients who don't present with CU traits?

6. Does the presence of CU traits affect practitioners' interpretation of ambiguous and unambiguous client information (practitioner appraisal of client intelligence, appearance, and definition of the term self-confident as it applies to the client in their case description)?
7. Does the global appraisal of client likability influence practitioners' investment in treatment, likelihood of referral, anticipated therapy effectiveness, and evaluation of trait information (practitioner appraisal of client intelligence, appearance, and definition of the term self-confident as it applies to the client in their case description)?
8. Are practitioners aware of how their global evaluations of client likability influence their evaluations of specific client traits (intelligence, appearance, and definition of self-confident as it applies to the client in their case description) and anticipated therapy effectiveness?

Chapter 3: Method

Participants

Participants were recruited by sending an email to the researcher's colleagues, supervisors, and professors in the mental health field that described the project, solicited their participation, and provided a link to access the study survey; email recipients were asked to forward the email to other mental health professionals. Potential recruits were informed both in the email and at the site (Survey Monkey) that a minimum of two years experience working in the mental health field was required to participate in the study. A total of 153 participants responded to the survey. Participants were randomly assigned to one of two groups: one group read a hypothetical case description of a client who did not present with CU traits (non-CU trait group [NCU group]) while the other group read the same case description as the NCU group but with the addition of CU Traits (CU trait group [CU group]; see Appendix A). Table 1 presents the frequency and percentages of demographic characteristics of participants. For both the NCU and CU groups, almost half of the participants identified themselves as between 21-29 or 30-39 years of age (n = 87, 58.7%).

In terms of gender, 76.5% of the total sampled participants were female (n = 114) while almost all the participants categorized themselves as White (n = 140, 94.0%). With regard to the license of participants, 39 participants (51.3%) in the NCU Group while 40 participants (53.3%) in the CU Group were licensed mental health practitioners. Moreover, regarding the highest degree of education achieved, 3 (2.0%) participants earned their Bachelors Degree, 4 (2.6%) were in a masters degree program, 21 (13.9%) participants had their Masters Degree, 54 participants (35.8%) were in a doctoral program, and 69 participants (45.7%) had completed their doctoral degree.

Measures

Therapist Appraisal Questionnaire. Practitioners' primary appraisals were measured using an adapted version of the Therapist Appraisal Questionnaire (TAQ; Fauth, Hayes, Park, & Freedman, 1999), a 20-item measure, that uses a Likert-type scale (ranging from 0 = not at all to 5 = a great deal; see Appendix B), and is comprised of the *Threat* scale (confident-reversed scored, worried, fearful, anxious), *Harm* scale (angry, disappointed, disgusted, sad and guilty), and *Challenge* scale (exhilarated, hopeful, eager, happy, energetic, and excited). The TAQ has demonstrated internal consistency with alpha coefficients ranging from .71 to .90 (Cooley & Klinger, 1989; Fauth et al., 1999). Construct validity for the TAQ is evidenced in the Therapist Challenge and Negative Stress (which consist of the Threat and Harm scale) scale scores' association with therapist self-efficacy, hesitance, GAF, Avoidance Index, and prognosis scores (Fauth & Hayes, 2006, Fauth et al., 1999).

Treatment investment. Participants were asked to answer, "I believe I would invest as much time and energy into this client as I would other clients" using a 5-point Likert-type scale (ranging from 0 = Strongly Disagree to 4 = Strongly Agree).

Likelihood of referral. Participants were asked to answer, "If possible, I would refer this client to another mental health practitioner" using a 5-point Likert-type scale (ranging from 0 = Strongly Disagree to 4 = Strongly Agree).

Anticipated therapy effectiveness. Participants were asked to answer, "Based on the information provided to you about Michael [the client], how effective do you expect therapy will be?" using a 7-point Likert-type scale (ranging from 0 = Completely Ineffective to 7 = Very Effective).

CU trait experience. Participants were asked to answer, "Individuals with callous and unemotional traits lack empathy, guilt, or emotional responsivity. About how many clients have you worked with that exhibit callous and unemotional traits?" using a 5-point Likert-type scale (1 = none; 2 = 1-5 clients; 3 = 6-10 clients; 4 = 11-19 clients; 5 = 20 or more clients).

CU trait knowledge. Participants were asked to answer, "How familiar are you with the literature on callous and unemotional traits?" using a 5-point Likert-type scale (1 = No knowledge; 2 = Have heard about the research; 3 = Read an article; 4 = Have read several articles; 5 = Read and am current on most of the literature).

Client likability. *Similar* to Stoler's (1963) rating of client likability, participants were instructed to "Please rate the specific liking or disliking feeling that this client brings out in you and best describes your reaction to Michael" on a 6-point Likert-type scale (ranging from 1 = Extremely Likable to 6 = Extremely Unlikable):

Practioners' appraisal of intelligence (PAIn). In both case descriptions, the client was described as falling "within the average range for intelligence" which corresponds to a scaled score on the Wechsler Intelligence Scale for Children-Fourth Edition (WISC-IV) of 85-115 using the Normative Descriptive System and 90-109 using the Traditional Descriptive System (Flanagan & Kaufman, 2004). Subsequent to reading the case description (and without the opportunity to return to the original case description), participants were asked, "based on the client description, estimate Michael's standard score on the Wechsler Intelligence Scale for Children-Fourth Edition (WISC-IV)." They then were prompted to select one of the following categories: 1 = 79 and below; 2 = 80-89; 3 = 90-99; 4 = 100-109; 5 = 110-119; and 6 = 120 and above.

Practitioners' appraisal of appearance (PAA). All participants (i.e., both the NCU Group and the CU Group) were shown a picture of Michael and asked to rate his attractiveness on a 7-point Likert-type scale (1 = Extremely Unattractive; 2 = Very Unattractive; 3 = Unattractive; 4 = Average Looking; 5 = Attractive; 6 = Very Attractive; 7 = Extremely Attractive).

Practioners' interpretation of self-confident. Participants read the following statement: "Michael's teachers and peers report that Michael is 'self-confident.' Please select which sentence you believe best describes this trait in Michael." Participants were then asked to select one of the following two choices: Self-Confident Description A: Michael is poised, confident in his own self-worth, and self-assured; or Self Confident Description B: Michael is excessively confident, arrogant, and not subject to another's authority.

Perceived practitioner awareness. At the end of the questionnaire, and consistent with Nisbett and Wilson's (1977b) methodology, practitioners were asked to rate, "How much, if at all, did your liking or disliking of Michael influence the decisions you just made?" Using a 6-point Likert-type scale (ranging from 1 = Much Lower to 6 = Higher), participants then indicated how much their liking or disliking influenced their assessment of the following variables: intelligence, appearance, therapy effectiveness and interpretation of Michael's "self-confidence."

Procedure

Participants were recruited by sending an email to the investigator's professors, colleagues and peers that described the project, solicited their participation and asked that the email be passed along to other potential participants or appropriate professional listservs. Participants were directed to Survey Monkey, an online survey tool, to gather participant

responses; there, they were informed that their "participation in this study will contribute to my dissertation on how certain client characteristics affect mental health practitioners and therapy." After reading their randomly assigned case description (the Non-CU Trait Group [NCU Group], the case description without CU traits or the CU Group, the case description with CU traits, see Appendix A), participants were prompted to answer a series of questions. To eliminate potential confounding variables, both the NCU Group and the CU Group were provided *almost* identical case descriptions, the only difference being the addition of a three-sentence statement describing the client's callous and unemotional traits in the CU Group (See Appendix A for case descriptions for each group). Once data were collected, statistical analyses were performed using the Statistical Packages for Social Sciences (SPSS).

Chapter 4: Results

Descriptive Statistics

This section presents the demographic characteristics of the participants gathered for this quantitative research study. Additionally, descriptive statistics for study measures are presented. A total of 153 participants responded to the survey. However, there are several items where participants opted to skip the question. Thus, there are variables that have a total sample size of less than 153.

Participants were randomly assigned to either the non-CU trait (NCU) Group or the CU trait (CU) Group. Participants who were assigned to the NCU Group were asked to read a case description of an adolescent delinquent client who did not present with CU traits; participants who were assigned to the CU Group read the same case description as the NCU Group, but their case description included information that indicated their client was high in CU traits (see Appendix A). Table 1 presents the frequencies and percentages of the demographic characteristics of participants. For both Groups combined, 34.0% (n = 51) were between 21-29 years of age, 24.7% (n = 37) were between 30-39 years of age, 14.7% (n = 22) were 40-49 years of age, 16.7% (n = 25) were between 50-59 years of age, and 10.0% (n = 15) were 60 years of age or older. Together then, 58.7% (n = 88) of participants were under 40 years of age.

Table 1

Frequency and Percentages of Demographic Characteristics of Sampled Participants

Demographic	Group				Total	
	NCU		CU			
	n	%	*n*	%	*n*	%
Age						
21-29	28	37.3%	23	30.7%	51	34.0%
30-39	17	22.7%	20	26.7%	37	24.7%
40-49	9	12.0%	13	17.3%	22	14.7%
50-59	9	12.0%	16	21.3%	25	16.7%
60 or older	12	16.0%	3	4.0%	15	10.0%
Total	75	100.0%	75	100.0%	150	100.0%
Gender						
Male	20	26.7%	15	20.3%	35	23.5%
Female	55	73.3%	59	79.7%	114	76.5%
Total	75	100.0%	74	100.0%	149	100.0%
Race						
White	71	95.9%	69	92.0%	140	94.0%
Black orAfrican American	0	.0%	2	2.7%	2	1.3%
Asian	2	2.7%	1	1.3%	3	2.0%
From multiple races	1	1.4%	3	4.0%	4	2.7%
Total	74	100.0%	74	100.0%	149	100.0%
Licensure						
I am a licensed mental health practitioner	39	51.3%	40	53.3%	79	52.3%
I am not a licensed mental healthpractitioner	37	48.7%	35	46.7%	72	47.7%
Total	76	100.0%	75	100.0%	151	100.0%
Highest Degree of Education						
Bachelor’s degree	2	2.6%	1	1.3%	3	2.0%
I am a student in a master’s degree program	3	3.9%	1	1.3%	4	2.6%
master’s Degree	8	10.5%	13	17.3%	21	13.9%
I am a student in a doctoral degree program	24	31.6%	30	40.0%	54	35.8%
Doctoral Degree	39	51.3%	30	40.0%	69	45.7%
Total	76	100.0%	75	100.0%	151	100.0%

Note. NCU = non-CU trait Group; CU = CU trait Group.

In terms of gender, 76.5% of the participants were female (*n* = 114). Almost all the participants categorized themselves as White (*n* = 140, 94.0%). Regarding the license of participants, 52.3% (*n* = 79) were licensed mental health practitioners, and 47.7% (*n* = 72) were not licensed mental health practitioners. Moreover, for the educational background, 2.0% (*n* = 3) had earned their bachelor's degree, 2.6% (*n* = 4) were students in a master's degree program, 13.9% (*n* = 21) earned their master's degree, 35.8% (*n* = 54) were in a doctoral program, and 45.7 % (*n* = 69) participants had completed their doctoral degree.

As shown in Table 2, the means for the NCU and CU Group were similar for both knowledge of CU traits and experience with CU trait clients. For the experience with CU trait client variable, the NCU Group mean was 2.91(*SD* =1.37) and the CU Group mean was 3.17 (*SD* = 1.38) on a 1 to 5 scale. Similarly, for the knowledge of CU trait literature variable, the NCU Group mean was 2.84 (*SD* = 1.32) and the CU Group mean was 3.17 (*SD* = 1.28) on a 1 to 5 scale. These data indicate that on average, participants in both groups had worked with approximately 6-10 clients and had some familiarity with the literature on CU traits ("read an article").

Table 2

Descriptive Statistics of Knowledge and Experience Variables

	Group	*n*	*M*	*SD*	*SE* Mean	Min	Max
Experience	NCU	75	2.91	1.37	0.16	1	5
	CU	75	3.17	1.38	0.16	1	5
Knowledge	NCU	76	2.84	1.32	0.15	1	5
	CU	75	3.17	1.28	0.15	1	5

Note. NCU = non-CU trait Group; CU = CU trait Group; Min = Minimum score; Max = Maximum Score.

Group Comparisons

Eight research questions were posed for this research study. In order to address these, independent samples *t*-test for comparison of means between groups, Spearman's correlation analysis, and regression analysis for investigating relationships among variables, and chi-square analysis for comparison of occurrences were performed using the Statistical Packages for Social Sciences (SPSS). Prior to conducting independent samples *t*-tests, Levene's tests for equality of variance were performed in order to ensure that both the NCU and the CU Group had equal variances. Cohen's *d* was also calculated to determine effect size for all *t*-tests.

For the first research question, the independent variable was the presence of CU traits represented by the group of the participants in the NCU or CU Group and the dependent variables were the CT scores on the Harm, Threat, and Challenge scales on the TAQ. As observed in Table 3, the two groups did not have equal variances on the Challenge scale, therefore, pooled variance was used for the analysis which explains the non-integer value of *df* for the Challenge scale. The independent samples *t*-test revealed that the NCU Group scored significantly lower (*M* = 3.45, *SD* = 3.05, .95 CI [2.77, 4.13]) than the CU Group (*M* = 4.59, *SD*

= 3.59, .95 CI [3.78, 5.4]) on the Harm scale, $t(151) = -2.12$, $p = .04$. Conversely, the NCU Group scored significantly higher ($M = 8.61$, $SD = 5.44$, .95 CI [7.39, 9.83]) than the CU Group ($M = 5.32$, $SD = 4.44$, .95 CI [4.32, 6.32]) on the Challenge scale, $t[145.94)] = 4.09$, $p < .01$.

These results showed that when practitioners read about CU trait clients they experienced more negative CT (Harm scale is comprised of angry, disappointed, disgusted, sad, and guilty) as compared to practitioners who read about clients who did not present with CU traits. These data also indicate that practitioners who read about non-CU trait clients experienced more positive CT (Challenge scale is comprised of exhilarated, hopeful, eager, happy, energetic, and excited) as compared to practitioners who read about CU trait clients. Additionally, consistent with Cohen's (1988) interpretation of effect size, the Challenge scale had a large effect size and the Harm scale had a medium effect size. These findings provide sufficient evidence to reject the first null hypothesis that the presence of CU traits, in an otherwise similar case description, does not affect countertransference, as measured by practitioners' primary appraisal.

Table 3

Independent Samples t-test Comparing the Means of the Challenge, Threat, and Harm Scales Between the NCU and CU Groups.

TAQ scale	*F*	*t*	*df*	Cohen's *d*
Challenge scale	4.31	4.09**	145.94	0.66
Threat scale	1.31	-1.49	151	0.24
Harm scale	1.30	-2.12*	151	0.34

Note. TAQ = Therapist Appraisal Questionnaire.
$^*p < .05$. $^{**} p < .01$.

For the second research question, independent samples *t*-tests were again used to assess whether a significant difference existed between the variables treatment investment, likelihood of referral, and anticipated therapy effectiveness for the NCU and CU Group. These variables were measured using four Likert-type scale questions: "I believe I would invest as much time and energy into this client as I would other clients," "If possible, I would refer this client to another mental health practitioner," and "Based on the information provided, how effective do you expect therapy will be?"

As observed in Table 4, the results showed that participants in the NCU Group were more invested in treatment (M = 4.51, SD = 0.53, .95 CI [4.39, 4.63]) than the CU Group (M = 4.07, SD = 0.87, .95 CI [3.87, 4.27]), $t(151) = 3.79$, $p < .01$, and that they anticipated that therapy would be more effective for their clients (M = 5.81, SD = 0.80, .95 CI [5.63, 5.99]) than for participants in the CU Group (M = 4.07, SD = 0.87, .95 CI [3.87, 4.27]), $t(139.75) = 37.31$, $p <$ .01. Further, participants in the CU Group were more likely to refer their clients (M = 2.22, SD = 1.15, .95 CI [1.96, 2.48]) than participants in the NCU Group (M = 1.76, SD = 0.98, .95 CI [1.54, 1.98]), $t(151) = -2.72$, $p = .01$. Since unequal variances were discovered for the anticipated

therapy effectiveness variable, pooled variance was used for the comparison of means analysis of anticipated therapy effectiveness. Additionally, consistent with Cohen's (1988) interpretation of effect size, the treatment investment (d = 0.61), and anticipated therapy effectiveness (d = 1.19) variables had a large effect and the likelihood of referral variable (d = 0.44) had a medium effect size. These findings provide sufficient evidence to reject the second null hypothesis that no difference exists between the variables treatment investment, likelihood of referral, and anticipated therapy effectiveness between the NCU and CU Group.

Table 4

Independent Samples t-test Comparing Mean Practitioner Treatment Investment, Likelihood of Referral, and Anticipated Treatment Effectiveness Scores Between the NCU and CU Groups

Variable	*F*	*t*	*df*	Cohen's *d*
Treatment investment	0.13	3.79**	151	0.61
Likelihood of referral	1.33	-2.72*	151	0.44
Anticipated treatment effectiveness	14.33	7.31**	139.75	1.19

Note. *$p < .05$. ** $p < .01$.

In order to understand if there was a relationship between practitioner knowledge of and experience with CU trait clients and countertransference, both a Spearman's correlation analysis and a regression analyses were conducted to assess the relationships between the knowledge and experience variables and scores on the Challenge, Threat, and Harm scales. As observed in Table 5, there were no significant relationship between knowledge of and experience with CU trait clients and CT scale scores.

Table 5

Spearman's Correlation Analysis of TAQ Scale Scores and Knowledge and Experience Scores of Participants in the CU Group

Variable	Challenge scale	Threat scale	Harm scale	Experience	Knowledge
Challenge	_____				
Threat	-.31**	_____			
Harm	.03	.58**	_____		
Experience	.07	-.19	-.22	_____	
Knowledge	.07	-.01	-.06	.44**	_____

Note. ** $P < .01$.

Furthermore, the regression analysis results presented in Tables 6 to 8 analyzed whether knowledge of and experience with CU trait clients were significant predictors of CT as measured by the Challenge, Threat, and Harm scales on the TAQ. The results of the correlation analyses were consistent with the below regression analyses because the variables of knowledge and experience were not significant predictors of Challenge, Threat, and Harm scales respectively. Moreover, the low R^2 values suggest that the predictor variables, knowledge of CU traits and experience with CU trait clients, did not predict the Challenge, Threat, and Harm scores. Therefore, there was insufficient evidence to reject the third null hypothesis which states that there is no relationship between practitioner knowledge of and experience with CU trait clients and negative countertransference as measured by practitioners' primary appraisal.

Table 6

Regression Analysis of Knowledge and Experience Scores as Predictors of Challenge Scale Scores of Participants in the CU Group

		Unstandardized coefficients		Standardized coefficients	
	Model	*b*	*SE*	ß	*t*
1	(Constant)	3.78	1.59		2.38*
	Experience	0.50	0.42	0.15	1.17
	Knowledge	0.00	0.46	0.00	0.00

Note. $R^2 = .02$.
$*p < .05$.

Table 7

Regression Analysis of Knowledge and Experience Scores as Predictors of Threat Scale Scores of Participants in the CU Group

		Unstandardized coefficients		Standardized coefficients	
	Model	*b*	Std. Error	ß	*t*
1	(Constant)	7.78	1.07		7.30**
	Experience	-0.42	0.28	-0.19	-1.50
	Knowledge	0.11	0.31	0.05	0.35

Note. $R^2 = .03$.
** $p < .01$.

Table 8

Regression Analysis of Knowledge and Experience Scores as Predictors of Harm Scale Scores of Participants in the CU Group

		Unstandardized coefficients		Standardized coefficients	
	Model	*b*	*SE*	ß	*t*
1	(Constant)	6.55	1.26		5.21**
	Experience	-0.50	0.33	-0.19	-1.49
	Knowledge	-0.10	0.36	-0.03	-0.27

Note. $R^2 = .04$.
** $p < .01$.

For the fourth research question, two analyses were used to understand the relationship between practitioner knowledge of and experience with CU trait clients and other variables. A Spearman's correlation analyses was again used to assess whether there is a relationship between the CU Group's knowledge of and experience with CU trait clients and the following variables: treatment investment, likelihood of referral, anticipated therapy effectiveness, client likability, and practitioners' evaluation of trait information (client intelligence, appearance, and definition of self-confident). However, independent samples *t*-tests were performed to determine whether knowledge and experience were related to practitioners' definitions of self-confident as it applied to the client in their case description. No significant difference was found for both knowledge (positive interpretation of self-confident: [*M* = 3.03, *SD* = 1.25]; negative interpretation of self-confident: [*M* = 3.09, *SD* = 1.34]) and experience (positive interpretation of self-confident: [*M* = 2.91, *SD* = 1.33]; negative interpretation of self-confident: [*M* = 3.21, *SD* = 1.38]) variables and the two choices for the definition of self-confident (Table 9).

Table 9

Independent Samples t-test Comparing the Positive and Negative Definition of Self-confident and Knowledge and Experience Scores

Variable	*F*	*t*	*df*	Cohen's *d*
Experience	0.87	-1.29	14	0.22
Knowledge	1.56	-0.30	14	0.05

As observed in Table 10, only a relationship between likelihood of referral (M = 1.99, SD = 1.09) and knowledge (M = 3.01, SD = 1.30) was found (r_s = -.17, p = .04). Since the relationship between these two variables was negative, this indicated that a higher knowledge score was observed when the likelihood of referral was low.

Table 10

Spearman's Correlation Analysis for Knowledge and Experience Scores and Other Variable Scores

Variable	Experience	Knowledge
Treatment Investment	.02	.06
Likelihood of referral	-.15	-.17*
Anticipated treatment effectiveness	.06	.03
Client likability	-.08	-.12
Practitioner appraisal of intelligence	-.02	.12
Practitioner appraisal of appearance	-.02	-.04

Note. * $p < .05$.

The results of the above correlation analyses were consistent with the regression analyses (see Tables 11-16) and indicated that the variables of knowledge and experience were not significant predictors of treatment variables (treatment investment, anticipated therapy effectiveness, client likability, practitioner appraisal of intelligence and practitioner appraisal of appearance). Moreover, the low R^2 values show that the predictor variables of knowledge and experience with CU trait clients did not predict the scores for the above listed treatment variables. Therefore, there is insufficient evidence to reject the fourth null hypothesis which states that there is no relationship between practitioner knowledge about and experience with CU trait clients and treatment investment, anticipated therapy effectiveness, client likability, and practitioners' evaluation of intelligence and appearance.

Table 11

Regression Analysis of Knowledge and Experience Scores as Predictors of Treatment Investment Scores of Participants in the CU Group

		Unstandardized coefficients		Standardized coefficients	
	Model	*b*	*SE*	ß	*t*
1	(Constant)	3.71	0.32		11.76**
	Experience	0.01	0.08	0.02	0.17
	Knowledge	0.10	0.09	0.14	1.08

Note. $R^2 = .02$.
** $p < .01$.

Table 12

Regression Analysis of Knowledge and Experience Scores as Predictors of Likelihood of Referral Scores of Participants in the CU Group

		Unstandardized coefficients		Standardized coefficients	
	Model	*b*	*SE*	ß	*t*
1	(Constant)	3.04	0.40		7.69**
	Experience	-0.13	0.11	-0.16	-1.27
	Knowledge	-0.11	0.11	-0.13	-1.00

Note. $R^2 = .06$.
** $p < .01$.

Table 13

Regression Analysis of Knowledge and Experience Scores as Predictors of Anticipated Treatment Effectiveness Scores of Participants in the CU Group

		Unstandardized coefficients		Standardized coefficients	
	Model	*b*	*SE*	ß	*t*
1	(Constant)	4.63	0.38		12.09**
	Experience	0.03	0.10	0.04	0.31
	Knowledge	-0.02	0.11	-0.02	-0.18

Note. $R^2 = .00$.
** $p < .01$.

Table 14

Regression Analysis of Knowledge and Experience Scores as Predictors of Client Likability Scores of Participants in the CU Group

		Unstandardized coefficients		Standardized coefficients	
	Model	*b*	*SE*	ß	*t*
1	(Constant)	3.97	0.19		21.03**
	Experience	-0.04	0.05	-0.09	-0.69
	Knowledge	-0.10	0.05	-0.23	-1.81

Note. $R^2 = .08$.
** $p < .01$.

Table 15

Regression Analysis of Knowledge and Experience Scores as Predictors of Practitioner Evaluation of Intelligence Scores of Participants in the CU Group

		Unstandardized coefficients		Standardized coefficients	
	Model	*b*	*SE*	ß	*t*
1	(Constant)	3.47	0.27		13.06**
	Experience	-0.01	0.07	-0.02	-0.14
	Knowledge	0.10	0.08	0.17	1.31

Note. $R^2 = .03$.
** $p < .01$.

Table 16

Regression Analysis of Knowledge and Experience Scores as Predictors of Practitioner Evaluation of Appearance Scores of Participants in the CU Group

		Unstandardized coefficients		Standardized coefficients	
	Model	*b*	*SE*	ß	*t*
1	(Constant)	4.61	0.17		27.97**
	Experience	-0.01	0.04	-0.03	-0.25
	Knowledge	-0.09	0.05	-0.24	-1.93

Note. $R^2 = .07$.
** $p < .01$.

For the fifth research question, an independent samples *t*-test was conducted for the comparison of the NCU and the CU Groups' mean client likability scores. Since the significance value of the Levene's test was less than .05, indicating unequal variances between the NCU and the CU Group, pooled variance was used for the analysis. As observed, client likability is significantly different between the NCU (M = 3.56, SD = 0.55, .95 CI [3.44, 3.68]) and the CU Group (M = 2.88, SD = 0.52, .95 CI [2.76, 3.00]) indicating that NCU Group was evaluated as more likable than the CU Group, $t(148.05) = -7.81$, $p < .01$, $d = 1.27$. Consistent with Cohen's (1988) interpretation of effect size, these data indicate that client likability had a large effect size. These findings provide sufficient evidence to reject the fifth null hypothesis that no difference exists between the likability of the NCU and CU Group.

For the sixth research question analyses were performed to determine whether or not the presence of CU traits affects practitioners' interpretation of client information (practitioners' appraisal of intelligence [PAIn] and practitioners' appraisal of appearance [PAA] and their definition of self confident as it applies to the client in their case description [DSC]). Independent samples *t*-tests again were conducted for the comparison of means of practitioners' appraisal of intelligence (PAIn) and practitioners' appraisal of appearance (PAA) scores of the NCU and CU Group. Table 17 presents the results of the analysis that showed that there is no significant difference between the PAIn (NCU Group: $M = 3.76$, $SD = 0.75$; CU Group: $M = 3.89$, $SD = 0.59$) and PAA (NCU Group: $M = 4.28$, $SD = 0.48$; CU Group: $M = 4.23$, $SD = 0.56$]) scores of participants according to the presence of CU traits.

Table 17

Independent Samples t-test Comparing Practitioners' Appraisal of Intelligence (PAIn) and Appearance (PAA) between the Non-CU Trait and the CU Trait Group

	F	*t*	*df*	Cohen's *d*
PAIn	5.99	1.20	139.73	0.19
PAA	0.01	-0.51	151.00	0.10

However, DSC differed significantly between the NCU and CU Group, χ^2 (1, *N* = 146) = 55.52, $p < .01$, $d = 1.51$. As observed in Table 18, 80% (*n* = 58) of the NCU Group was more likely to interpret "self-confident" when used to describe Michael as meaning he was "poised, confident in his own self-worth, and self-assured" while 82% (*n* = 60) of the CU Group was more likely to interpret "self-confident" when used to describe Michael as meaning he was "excessively confident, arrogant, and not subject to another's authority." While there was sufficient evidence to reject the null hypothesis that there is no difference for DSC between the NCU and CU groups, there was not sufficient evidence to reject the null hypothesis that there is no difference in PAIn and PAA between the NCU and CU group.

Table 18

Cross-tabulation Comparison of Practitioners' Definition of Self-confident as it Applied to Their Client (DSC) between the Non-CU Trait (NCU) and the CU (CU) Trait Group

Choices for DSC	Group		Total
	NCU	CU	
Poised, confident in his own self worth, and self-assured.	58	13	71
Excessively confident, arrogant, and not subject to another's authority.	15	60	75
Total	73	73	146

Note. χ^2 (1, N = 146) = *55.52, p < .01.*

As presented in Tables 19 and 20 and in response to research question 7, it was determined that the global appraisal of client likability was not related to practitioners' appraisal of appearance (PAA; M = 4.26, SD = 0.52) or intelligence (PAIn; M = 3.83, SD = 0.68). However, practitioners' treatment investment (r_s = -.39, p < .01), likelihood of referral (r_s = .44, p < .01), and anticipated therapy effectiveness scores (r_s = -.38, p < .01) were related to client likability.

Table 19

Spearman's Correlation Analysis of Client Likability Scores and Practitioner Appraisal of Intelligence (PAIn) and Appearance (PAA) Scores

	Client likability	PAIn	PAA
Client likability	_____		
PAIn	-.10	_____	
PAA	-.05	.08	_____

Table 20

Spearman's Correlation Analysis of Client Likability Scores, Anticipated Treatment Effectiveness, and Likelihood of Referral Scores

Variable	Treatment Investment	Likelihood of referral	Anticipated treatment effectiveness	Client likability
Treatment Investment	―			
Likelihood of referral	-.47**	―		
Anticipated treatment effectiveness	.35**	-.38**	―	
Client Likability	-.39**	.44**	-.59**	―

Note. **$p < .01$.

There also was a significant relationship between client likability and DSC scores ($r_s = .50$, $p < .01$). Therefore, the global appraisal of client likability was related to practitioners' definition of "self-confident" as it applied to the client in their case description.

In further analyzing the relationship between client likability and treatment investment, likelihood of referral, anticipated therapy effectiveness, PAIn, PAA, and DSC, the responses of participants were classified according to likable and unlikable. Participant ratings of 1, 2, or 3 on client likability were categorized as "likable" responses; ratings of 4, 5, or 6 were categorized as "unlikable." As shown in Table 21, practitioners anticipated therapy would be more effective, $t(67.01) = 6.90$, $p < .01$, $d = 1.30$ were less likely to refer, $t(63.06) = -4.78$, $p < .01$, $d = 0.90$, and were more invested in treatment, $t(148) = 4.78$, $p < .01$, $d = 0.78$ with likable clients as compared to unlikable clients. Further, likable clients were assigned a more favorable definition of the adjective self-confident as compared to unlikable clients, $t(106.28) = -6.37$, $p < .01$, $d = 1.30$.

When doing the analyses, the Levene's test results demonstrated significantly different variances between the likable and unlikable groups, therefore, pooled variance was used to calculate and analyze the comparison of means for variables of treatment investment, likelihood of referral, anticipated therapy effectiveness, practitioner appraisal of intelligence, practitioner appraisal of appearance, and definition of self-confidence. Using Cohen's (1988) definition of effect size, likability had a large effect size (d = 1.30) on anticipated effectiveness of therapy, likelihood of referral, practitioners' investment in treatment, and practitioners' definition of self confident as it applied to their client. These data suggest that there was not sufficient evidence to reject the null hypothesis that there is no difference for PAIn and PAA between the likable and unlikable groups. However, there was sufficient evidence to reject the null hypothesis that there is no difference in practitioners' anticipated therapy effectiveness, likelihood of referral, how invested they would be in treatment, and DSC between the likable and unlikable groups.

Table 21

Descriptive Statistics of Anticipated Therapy Effectiveness, Likelihood of Referral, Practitioner Appraisal of Intelligence (PAIn) and Appearance (PAA), and Definition of Self-confident as it Applies to the Client in the Case Description (DSC) According to Client Likability

Treatment variable	Client likability category	*n*	*M*	*SD*	.95 CI	*SEM*
Treatment investment	Likable	105	4.47	0.59	[4.36, 4.58]	0.06
	Unlikable	45	3.87	0.92	[3.60, 4.14]	0.14
Likelihood of referral	Likable	104	1.69	0.85	[1.53, 1.85]	0.08
	Unikable	46	2.67	1.28	[2.30, 3.04]	0.19
Anticipated therapy effectiveness	Likable	105	5.64	0.82	[5.48, 5.80]	0.08
	Unlikable	46	4.37	1.12	[4.05, 4.69]	0.17
PAIn	Likable	103	3.86	0.67	[3.73, 3.99]	0.07
	Unlikable	44	3.75	0.69	[3.55, 3.95]	0.10
PAA	Likable	105	4.27	0.54	[4.17, 4.37]	0.05
	Unlikable	46	4.24	0.48	[4.10, 4.38]	0.07
DSC	Likable	100	1.37	0.49	[1.27, 1.47]	0.05
	Unlikable	44	1.84	0.37	[1.73, 1.95]	0.06

Note. CI = confidence interval

Finally, for the eighth research question, the categories likable and unlikable were again designated. Table 22 presents the descriptive statistics of practitioners' self assessment of how much their global appraisal of client likability influenced their rating of client intelligence, appearance, treatment investment, and self-confidence and highlights how the mean scores for the CU Group were negative while the mean scores for the NCU Group were positive. These

data indicate that for participants in the NCU Group, participants believed that their client's likability had more of an "influence" on the decisions they made about their client (regarding ratings of intelligence, appearance, anticipated therapy effectiveness, and interpretation of the descriptor "self confident") than for the CU Group.

Table 22

Descriptive Statistics of Practitioners' Self-assessment of How Much Client Likability "Influenced" Client and Therapy Ratings

Variable	Group	*n*	*M*	*SD*	*.95 CI*	*SEM*	Min	Max
Rating of intelligence	NCU	77	0.12	0.63	[-0.02, 0.26]	0.07	-3	1
	CU	75	-0.11	0.73	[-0.28, 0.06]	0.08	-3	1
Rating of appearance	NCU	77	0.10	0.60	[-0.03, 0.23]	0.07	-3	2
	CU	76	-0.11	0.76	[-0.28, 0.06]	0.09	-3	1
Anticipated therapy effectiveness	NCU	77	0.53	0.72	[0.37, 0.69]	0.08	-1	3
	CU	76	-0.26	0.85	[-0.45, 0.07]	0.10	-3	1
Definition of self-confident	NCU	77	0.34	0.80	[0.16, 0.52]	0.09	-2	2
	CU	74	-0.31	0.99	[-0.54, 0.08]	0.12	-3	2

Note. NCU = non-CU trait Group; CU = CU trait Group; CI = confidence interval; Min = minimum score; Max = maximum score.

Similarly, as observed in Table 23 and 24, mean scores for practitioners' evaluation of client likability's "influence" on appraisal of intelligence, appearance, anticipated therapy effectiveness, and definition of self-confident as it applied to the client in their case description for the unlikable group was negative while mean scores for practitioners' evaluation of client likability's influence on these same treatment variables was positive. These data indicates that "likability" in the unlikable clients had less influence on practitioners' ratings of intelligence, appearance, anticipated therapy effectiveness, and self-confidence while "likability" in likable clients appeared to have more influence on practitioners' ratings of intelligence, appearance, treatment investment, and self-confidence.

Table 23

Descriptive Statistics of Evaluation Scores According to Client Likability (CL)

Variable	Client likability category	*n*	*M*	*SD*	.95 CI	*SEM*
CL "influence" on rating of intelligence	Likable	105	0.13	0.61	[0.01, 0.25]	0.06
	Unlikable	45	-0.29	0.79	[-0.52, -0.06]	0.12
CL "influence" on rating of appearance	Likable	105	0.13	0.59	[0.02, 0.24]	0.06
	Unlikable	46	-0.30	0.81	[-0.53, -0.07]	0.12
CL "influence" on rating of anticipated therapy effectiveness	Likable	105	0.43	0.71	[0.29, 0.57]	0.07
	Unlikable	46	-0.52	0.91	[-0.78, -0.26]	0.13
CL "influence" on definition of self-confident	Likable	104	0.26	0.78	[0.11, 0.41]	0.08
	Unlikable	45	-0.53	1.12	[-0.83, -0.23]	0.17

Note. CI = confidence interval.

Through the Levene's test, pooled variance was used to calculate the *t*-statistic for the independent samples *t*-test of practitioners' ratings of client likability's "influence" on their ratings of appearance, and practitioners' ratings of client likability's "influence" on DSC. Based on the results of the independent samples *t*-tests presented in Table 24, practitioners believed that likable clients had more influence on their ratings of intelligence, $t(148) = 3.57$, $p < .01$, appearance, $t(66.59) = 3.29$, $p < .01$, anticipated therapy effectiveness, $t(149) = 6.95$, $p < .01$, and DSC, $t(63.00) = 4.32$, $p < .01$ than unlikable clients. The effect size of likability on practitioners' ratings of client intelligence ($d = 0.60$) and appearance ($d = 0.61$) was medium; for the variables of anticipated therapy effectiveness ($d = 1.16$) and definition of self-confident as it applies to their client ($d = 0.82$) the effect size was large (Cohen, 1988).

Table 24

Independent Samples t-test for Comparison of Evaluation Scores according to Client likability (CL)

Variable	*F*	*t*	*df*	Cohen's *d*
CL impact rating of intelligence	3.71	3.57**	148	0.60
CL impact rating of appearance	5.68	3.29**	66.59	0.61
CL impact rating of TE	2.54	6.95**	149	1.16
CL impact interpretation of DSC	14.30	4.32**	63.00	0.82

Note. TE = Anticipated therapy effectiveness; DSC = definition of self-confident as it applies to the client in the case description.
** $p < .01$.

Summary

The results demonstrated that overall, practitioners responded more negatively (negative countertransference) to client case descriptions that included CU traits than to those that did not. Additionally, practitioners who read case descriptions of clients with CU traits were less invested in treatment, more likely to refer their client, and anticipated that treatment would be less effective as compared to practitioners who read case descriptions of clients without CU traits. However, correlation analysis and regression analyses determined that there was no significant relationship between practitioner knowledge of and experience with CU traits and practitioner negative countertransference. Additionally, while there was no relationship between practitioner knowledge of and experience with CU trait clients and other treatment variables (practitioner treatment investment, anticipated therapy effectiveness, client likability), our results showed that the more knowledge a practitioner has about CU traits, the less likely they were to refer a client with CU traits.

Participants in this study globally assessed clients without CU traits (the NCU Group) as significantly more likable than clients with CU traits (the CU Group). Further, participants in the NCU Group were more likely to choose the more favorable interpretation of the adjective “self-confident” to describe their client than particiapants in the CU Group. However, no significant difference was found between practitioners’ appraisal of client intelligence and appearance between the NCU and the CU Groups. While the global appraisal of client likability was not related to pratitioners’ appraisal of more specific traits (appearance and intelligence), it was related to treatment investment, likelihood of referral, anticipated therapy effectiveness, and how they interpreted the adjective “self-confident” as it applied to their client. Last, the results demonstrated that practitioners who rated their client as “likable” believed “likability” “influenced” their evaluations of client intelligence, appearance, interpretation of ambiguous client information, and anticipated therapy effectiveness more than the “likability” of clients who were rated as “unlikable.”

Chapter 5: Discussion

Introduction

This study examined whether or not the addition of callous and unemotional (CU) traits in an otherwise identical case description would affect practitioner countertransference (CT), appraisal of both global and specific client traits, and other therapy-relevant variables. Additionally, whether or not there was a relationship between practitioner knowledge of and experience with CU trait clients and practitioner CT, client appraisal, and evaluation of other client and therapy variables was investigated. Data were collected using an online survey that incorporated the Therapist Appraisal Questionnaire (TAQ), and questions that measured the following practitioner and treatment variables: treatment investment, likelihood of referral, anticipated therapy effectiveness, CU trait experience, CU trait knowledge, client likability, appraisal of intelligence, appraisal of attractiveness, appraisal of the meaning of the word self-confident, and practitioner's beliefs about how much likability influenced their ratings of clients and therapy. A total of 153 mental health practitioners participated in this study. Statistical analyses such as independent samples *t*-tests, correlation analyses, regression analyses, and chi-square analyses were used to analyze these data. This section provides a discussion of the findings, clinical implications, and limitations of this study.

A quantitative causal-comparative study was conducted to examine whether the presence of CU traits affected practitioner countertransference (CT), appraisal of client and other therapy variables. Participants were randomly assigned to read either a case description of a client where CU Traits are absent (the NCU Group) or a case descriptions of a client who exhibited CU traits (the NCU Group). Based on the 153 participants in this study, 77 participants were assigned to

the NCU Group while 76 participants were assigned to the CU Group. Eight research questions were addressed using a variety of statistical analyses.

CU Traits and Countertransference

This study's findings are consistent with the research hypothesis that mental health practitioners have negative responses to clients who present with high CU traits. Specifically, practitioners experienced feelings of anger, disappointment, disgust, sadness, and guilt (Harm scale) in response to client descriptions that included CU traits versus client descriptions where CU traits were absent. Similarly, practitioners felt more exhilarated, hopeful, pleased, eager, happy, energetic, and excited (the Challenge scale) when reading about non-CU trait clients as compared to CU trait clients.

However, practitioners did not respond differently to clients with or without CU traits on the Threat scale, which measures the potential of damage or loss. This surprising result may indicate that the feelings measured in the Threat scale (confident [reverse scored], worried, fearful, anxious) don't capture the specific practitioner reactions evoked when reading about CU trait clients. Another possible explanation for this finding is that Threat scale reactions are evoked when reading about delinquent clients (the hypothetical client description in both the NCU and CU Group would fall into this category; See Appendix A), which would explain the similar, but high means in both groups.

Because even a small amount of negativity in therapists' reactions to clients impedes treatment, practitioners' negative CT in response to CU trait clients could negatively impact the process, alliance, and outcome of therapy (Gelso & Hayes, 2002; Najavits et al., 1995; Strupp, 1993). Not only is CT related to therapist withdrawal or overinvolvement in therapy (Gelso & Hayes, 2002), but also to clients' negative responses toward their therapists (Mathiesen, 2007;

Williams & Fauth, 2005). This suggests that clients who present with CU traits are more vulnerable to experiencing negative reactions to therapists than clients who do not present with CU traits. Indeed, such negative reactions could reinforce practitioners' negative appraisal of CU trait clients, increase the chance that clients drop out of therapy, and reify potential assumptions that high CU trait clients are "bad seeds," and unresponsive to treatment.

CU Traits and Other Treatment Variables

Practitioners' negative response to CU trait clients extends Fauth and Hayes's (2006) finding that therapist negative countertransference is related to therapist avoidance and hesitance with clients. Specifically, these results indicate that practitioners responding to the client description with CU traits not only were more likely to experience negative countertransference as discussed above, but also were more likely to refer their client, invest less in treatment, and have lower expectations about therapy effectiveness than practitioners who read client descriptions that did not include CU traits. Further, Mathieson's (2007) findings that therapists' positive emotional reactions to clients predict positive emotional and cognitive client reactions and perceptions of sessions may have implications for the present study. Specifically, since practitioners experienced more positive feelings and fewer negative feelings to nonCU trait clients as compared to CU trait clients, Mathieson's data suggest that clients without CU traits would respond more favorably than clients with CU traits to the therapeutic process which could be yet another contributing factor to CU trait clients' poor therapeutic outcomes.

Knowledge of and Experience with CU Trait Clients

Contrary to this study's research hypothesis that there is a positive relationship between practitioner knowledge of and experience with CU trait clients and negative CT, no relationship was found between practitioners' CT scores (Challenge, Threat, and Harm scales) and

knowledge of and experience with CU trait clients. Just as there was no relationship between knowledge of and experience with CU traits and CT, no relationship was found between practitioner knowledge of and experience with CU trait clients and other treatment variables (treatment investment, anticipated therapy effectiveness, client likability, and practitioners' evaluation of intelligence and appearance).

The above results also may indicate that practitioners are more resilient than anticipated to the difficulties associated with working with CU trait clients (i.e., burnout, concern about known ineffectiveness of therapy). However, these data didn't capture the frequency and intensity of exposure to CU trait clients (i.e., 5 clients in one week or 5 clients over 10 years) or whether or not practitioners had access to effective supports when working with difficult CU trait clients. Future studies that assess how the frequency and intensity of exposure to CU traits clients how practitioner access to supports impact practitioner burnout would allow for a more accurate interpretation of these data. Additionally, in terms of the "experience with CU trait client" variable, the mean number of CU trait clients participants have worked with may need to be greater than this study sample's mean of "about 6-10 clients" in order to affect practitioner CT and elicit negative evaluation of treatment variables. Future research that accesses practitioners who work with a higher volume of CU trait clients is recommended in order to better understand if and how experience with CU trait clients affects practitioner countertransference and other treatment variables.

This study's findings suggest that instead of increased knowledge resulting in practitioners' increased likelihood of referral, the opposite was found in that an increase in knowledge of CU traits was related to a lower likelihood of referral. One explanation for this result proposes that practitioners who are knowledgeable about the literature on CU traits

demonstrate a unique interest in this population, are motivated to learn about and work with high CU trait clients, and thus may be less likely to refer these clients to other practitioners. Further, perhaps practitioners who are knowledgeable about CU traits not only have more competence in this area, but also are less anxious and more confident working with this population. Last, it is important to consider the setting when treating difficult clients. Practitioners may be more comfortable treating a CU trait client in a secure setting (correctional facility vs. a private practice). Additionally, since juvenile treatment centers that have a smaller staff to youth ratio and implement longer treatment have demonstrated better outcomes than standard juvenile correctional institutions (Caldwell et al., 2007), practitioners who work in these settings may view CU trait clients as challenging and difficult (but not hopeless) and therefore be less susceptible to burnout and negative countertransference. Future studies that assess practitioners' setting could allow for a deeper understanding of how knowledge of and experience with CU trait clients is related to countertransference and other treatment variables.

CU Traits and the Halo Effect

This study's data indicate that the presence of CU traits was related to practitioners' global evaluation of client likability in that clients without CU traits were appraised as more likable than those who presented with CU traits. Since client likability is related to success in therapy, the "unlikability" of CU trait clients could be a contributing factor to their demonstrated poor therapeutic outcomes (Stoler, 1963). However, contrary to Nisbett and Wilson's (1977b) and Landy and Sigall's (1974) findings that global evaluations of a person's attributes (such as likability) significantly impact evaluations of their specific attributes, the global appraisal of client likability of CU trait clients only influenced how practitioners interpreted the adjective

self-confident when used describe their client, but not how practitioners evaluated their clients' intelligence or appearance.

One explanation for this finding is that the effect size of practitioners' ratings of intelligence and appearance was small (Cohen, 1988), and therefore a larger sample size is needed to detect a significance difference between the NCU and the CU Group. Or, perhaps the "forced choice" of definitions of self-confident as it applied to the client in their case description allowed for more robust results than the Likert-type scales used to measure practitioners' appraisal of intelligence and appearance. A more likely explanation, however, is that since practitioners were informed in both case descriptions that their client was assessed to be "within the average range for intelligence," their rating of intelligence didn't depart from the "average range" which was captured in the middle two selections of the Likert-type rating scale (1 = 79 and below; 2 = 80-89; 3 = 90-99; 4 = 100-109; 5 = 110-119; and 6 = 120); indeed these data indicate that for both the NCU and the CU Group, only 12% of participants deviated from choosing 3 or 4.

Similarly, both groups' similar assessment of their client as "Average Looking" may accurately capture this researcher's intent of using generically dressed and neutral-expressioned model for this study. Another plausible explanation may also reflect that neutrality and acceptance are more socially desirable traits for mental health practitioners than perhaps for the college students in Nisbett and Wilson's (1977b) and Landy and Sigall's (1974) studies whose global evaluations of people (i.e., a warm and friendly vs. a cold and distant professor in Nisbett and Wilson's study or an attractive vs. an unattractive female writer in Landy and Sigall's study) altered their evaluations of people's specific attributes (professor's appearance, mannerisms, and accent; writer's ability), even when there was adequate information for independent assessments.

Importantly, politically correct therapists may be averse to judging people's appearances and aware of the consequences and biases of such judgments. Therefore, practitioners in both the NCU and the CU Group's "average" ratings of their client's appearance (and perhaps intelligence too) may way well reflect an effort to preserve neutrality and avoid making judgments without even meeting their client in person.

However, the global evaluation of client likability was related to other aspects of client appraisal and treatment variables. Practitioners who assessed their client as "likable" not only were more likely to use the more favorable "self-confident" descriptor than practitioners who assessed their clients as "unlikable," but client likability was also related to practitioners' evaluation of anticipated therapy effectiveness, treatment investment, and likelihood of referral. These findings indicated that if the practitioner evaluated the client as likable, they would have higher expectations for therapy effectiveness, invest more time and energy into treatment and be less inclined to refer their client to another therapist as compared to an unlikable client. Since practitioners in this study appraised clients with CU traits as less likable than those without CU traits, and since "likability" was significantly related to their appraisal of more specific traits and other treatment variables, the results of this study are consistent with the halo effect. Based on these findings, CU trait clients are more likely than clients without CU trait clients to be globally assessed as unlikable; this global assessment affects the appraisal of more specific trait information and other treatment variables.

Practitioner Awareness of the Influence of Client Likability

Practitioners' ratings of how much their "liking or disliking" of their client "influenced the decisions" made about their client indicated that practitioners believed that likable clients had more of an "influence" than unlikable clients on practitioner decisions. Specifically, for

practitioners who rated their clients as likable, mean ratings on how their "liking or disliking" of their client "influenced" their decisions about client intelligence and appearance, anticipated therapy effectiveness, and definition of self-confidence (DSC) were positive, which showed that practitioners believed that "likability" did affect their decisions about their clients. Conversely, for practitioners who rated their client as unlikable, practitioner scores were negative across all of the above treatment variables. This showed that practitioners believed that their "disliking" of unlikable clients had little "influence" on their client decisions and is consistent with Nisbett and Wilson's (1977a) finding that subjects who saw a cold (vs. warm) instructor on video believed that their global rating of the instructor (dislike) had no effect on their rating of his specific attributes.

However, practitioners' self-evaluation was inconsistent with some of their ratings earlier on in the survey. That is, although practitioners at the end of the survey believed that client likability influenced their ratings on intelligence, appearance, treatment effectiveness, and DSC, their responses earlier in the survey didn't show any relationship between client likability and practitioners' rating of intelligence or appearance. Again, as mentioned above, this discrepancy might reflect not only mental health practitioners' allegiance to neutrality, but also may convey that practitioners' were aware of their "unliking" response and corrected for it when rating their clients' appearance and intelligence. However, practitioners demonstrated and were aware of the influence of likability on their definition of self-confident as it applied to the client in their case description and anticipated therapy effectiveness. That is, there was no discrepancy between practitioners evaluation of the influence of likability on these variables and how likability actually was related to the decisions they made about their client. Perhaps decisions about anticipated therapy effectiveness and choosing a definition of self-confident were perceived as

less potentially stigmatizing than rating clients on intelligence or appearance. As such, practitioners' evaluation of anticipated therapy effectiveness and definition of self-confident as it applied to the client in their case description may be more subtle indicators of practitioner client appraisal and therefore could have resulted in less practitioner monitoring.

Since self-awareness and reflectiveness are valued practitioner qualities and practitioners are taught that their beliefs and values have a ubiquitous influence on their way of negotiating interpersonal processes, it also is possible that in an effort to adhere to professionally desirable behavior, practitioners in this study stated that likability did influence their ratings, even if they did not. Similarly, since mental health practitioners are aware of the importance of empathy and cultivation of a therapeutic alliance to therapy effectiveness, practitioners might be reluctant to acknowledge that the unlikability of a client "influenced" decisions made about that client and therapy. For some, doing so might prompt practitioners to question their competence.

Gender and Training

Since 77% of this study's participants were female, it is important to consider how gender may have influenced the results of this study. The finding that participants who read about clients with CU traits had stronger negative reactions and were more likely to refer their clients and invest less in treatment than participants who read about clients without CU traits is inconsistent with previous research that found that when countertransference is activated for female therapists, they tend to become over-involved in therapy (Hayes et al., 1998; Rosenberger & Hayes, 2002). However, Mathieson (2007) had similar findings and hypothesized that females may have a greater tendency to be self-critical of their negative reactions, become preoccupied by them and ultimately disengage from treatment (i.e., refer their client or invest less in treatment). Although the above finding may be associated with gender, the fact that 39% of the

study participants were in a masters or doctoral degree program should also be considered. Since graduate students generally are in the beginning stages of their career, they may not have yet developed skills or been trained to effectively manage their negative reactions which could have contributed to a tendency to invest less in treatment with and refer clients CU traits clients.

Clinical Implications

The above findings have direct implications for clinical work. Although it has been established that therapists' emotional reactions to their clients are clinically relevant, practitioners who work with CU trait clients are indeed vulnerable to but may not be aware of or able to manage their negative responses (Gelso & Hayes, 2002; Patrick, 2007; Safran & Muran, 1996). Awareness of these responses and influence of negative appraisals could not only promote insight into the counseling relationship, but also minimize the negative therapeutic behavior that accompanies unexamined emotional responses (Gelso & Hayes, 1998; Singer & Luborsky, 1977). Importantly, cultivating such an awareness could result in more effective treatment for clients who exhibit callous and unemotional traits.

While there is a range of experience and professional training of mental health practitioners who work with clients high in CU traits, all would benefit from learning how to increase their awareness, acceptance and use of their negative responses to augment and inform their work with these difficult clients (Gelso et al., 2002; Gelso & Hayes, 2002; Strupp, 1980). Not only would effective use of supervision and a positive supervisory alliance facilitate this task, but so too would supervisors' employment of the Countertransference Factors Inventory (CFI) as a way to assess supervisees' personal attributes that are instrumental in helping them manage CT (Gelso et al., 2002). Similarly, since a positive therapeutic alliance is one of the best predictors of therapy outcome (Wampold, 2001) and client ratings are better predictors of

outcomes than therapists' (Bachelor & Horvath, 1999), measures used to assesses the client's view of the therapeutic relationship (i.e., the Session Rating Scale Version 3, the Outcome Rating Scale, The Helping Alliance Questionnaire II) could help practitioners monitor and influence its quality (Duncan, Miller, & Sparks, 2004).

Encouraging practitioners to develop and practice mindfulness skills could also mitigate against the difficulties associated with working with clients who exhibit CU traits. Mindfulness practice not only helps promote increased awareness and acceptance of emotions as they arise, but also cultivates concepts such as non-judgment and self-compassion (Shapiro & Carlson, 2009). Further, engagement in a mindfulness practice has demonstrated effectiveness for helping therapists regulate and create a holding space for emotions, particularly with difficult clients (Shapiro & Carlson, 2009). Practitioners who work with CU trait clients might also benefit from consistent use of the TAQ, or other measures used to assess CT to enhance self-awareness and gauge their reactions to clients.

Although attempts to treat individuals who exhibit callous and unemotional traits are typically unsuccessful, relatively little research has explored how these individuals conceptualize their world. However, in their research on psychopathic individuals[1], both Brody and Rosenfeld (2002) and Gullhaugen and Nøttestad (2011) concluded that object relations deficits are a core component of psychopathy. Specifically, these studies found that psychopaths had insecure attachment styles and that, despite their cavalier and calm presentation, psychopaths struggle with ongoing emotional pain that is often a result of childhood experiences of loss or rejection from caregivers or loved ones. In short, Brody and Rosenfeld assert that since psychopaths'

[1] "Psychopathy" and "psychopathic" are terms not officially recognized by the DSM-IV. However, 1-2% of the general population designate a subset of Antisocial Personality Disorder that exhibit severe emotional dysfunction, especially a lack of empathy and remorse (Cleckley, 1988; Hare, 1993; Neumann & Hare, 2008).

emotional and intimacy needs are associated with pain, these feelings are disavowed in order to avoid pain.

Consistent with Gullhaugen and Nøttestad (2011), who dispute the claim that psychopathy and emotional vulnerability are mutually exclusive, treatment of CU trait clients from an object relations framework could allow practitioners to explore the vulnerability and pain that is assumed to be absent in high CU trait individuals. Since individuals with CU traits typically don't consider the needs and complexity of others or differentiate others' needs from their own, developing and sustaining a relationship often is problematic for CU trait clients, particularly in therapy (Gullahaugen & Nøttestad, 2011). Gullahaugen and Nøttestad suggest that instead of focusing on the dominant interpersonal patterns of these individuals, practitioners should consider that the psychopath's mask of sanity serves to disguise their suffering. Seeing through this defense not only calls upon practitioners' natural inclination to help others who experience pain, but also cultivates practitioner empathy, a requisite component of effective therapy (Rogers, 1951). In short, since "in traditional diagnostics, we count symptoms, but lose the interpersonal drama of an individual's disease" (Gullhaugen & Nøttestad, 2011, p. 353), initiatives that aim to improve the treatment alliance with CU trait clients should consider increasing practitioners' awareness of the pain that often underlies CU traits by informing practitioners that CU trait clients' callous and unemotional symptoms often are the aggregate result of painful early experiences.

In response their review of 11 case studies, Gullhaugen and Nøttestad (2011) assert that a psychopath's emotional life is more nuanced and complex than once thought. For example, contrary to the assumption that high CU traits individuals exhibit and experience little emotion, with regard to positive feelings, Gullhaugen and Nøttestad found that there was little or no

difference between psychopathic and normal individuals. Certainly, practitioners who work with CU trait clients might be better able to access an empathic response and negate the stigma associated with working with a psychopath, “the least loved patient” (Strasburger, 1986, p. 191), if they are informed of their client’s history and understand the client’s emotional complexity. Further, and consistent with recent findings that children exposed to less physical punishment and more parental warmth over time showed decreases in CU traits, practitioners who work with CU trait clients should be attuned to the presence of negative countertransference or behaviors that are counter to these helpful responses (Pardini et al., 2007; Pasalich et al., 2011). Similarly, initiatives aimed at educating parents about the benefits of reward-based discipline techniques and providing them with the support and resources needed to promote quality parenting is also recommended (Loeber et al., 2009; Pasalich et al., 2011).

Although research into the treatment of adolescents with callous and unemotional traits is limited, some data suggest that these youth can respond to treatment. Caldwell et al. (2007) found that contrary to other studies that have been unable to identify effective treatment for youth with psychopathic features, their longer-term treatment of incarcerated youth (45 weeks) demonstrated treatment effects. Specifically, their data suggest that sustained treatment that is designed to manage difficult and disruptive clients, emphasizes both behavioral and social manifestations of antisocial conduct, allows for smaller staff to client ratios, and engages youth in the treatment process may contribute to treatment success. Although Caldwell et al. did not specify a focus on the therapeutic alliance for effective treatment and question whether treatment techniques could account for their demonstrated treatment effects, their better outcomes with incarcerated youth in longer-term treatment (as compared to other treatment settings’ shorter-term approach), and incorporation of youth into the treatment process is distinct and may

underscore the importance of prioritizing the therapeutic relationship when working with CU trait clients. Additionally, Cadwell et al. assert that since individuals with psychopathic features are "more likely to be screened out, to drop out, or to be expelled from treatment" (p. 592), treatment programs should be designed to manage and retain these individuals so that difficult clients can benefit from treatment.

In an effort to orient and acclimate to clients, practitioners often access client information prior to meeting with them. However, premature access to such information carries risks for designated CU trait clients. As demonstrated in this study, and consistent with previous findings where therapists responded negatively to written vignettes of clients with certain diagnoses (Brody & Farber, 1996), merely reading about a client who exhibits high CU traits elicits negative responses in practitioners, increases the likelihood that these clients will be referred, decreases practitioners' investment in treatment and their belief that therapy will be effective. Therefore, while assessment information about CU traits is intended to inform treatment, the known difficulty associated with working with CU trait clients and stigma now associated with CU traits could instead initiate a negative therapeutic trajectory. As such, practitioners who work with high CU trait clients might consider limited or appropriately delayed access to their clients' files in order to prophylax against the influence of others' assessments which could affect countertransference and global and specific client appraisals. Alternatively, underscoring the importance that practitioners tend to their vulnerability when working with CU trait clients and educating students and practitioners about the emotional complexity of CU trait clients might offset the negative influence of accessing client files prior to meeting them. Last, and consistent with Hare's intended use of the PCL-YV (Hare, 1998), practitioners should ensure the validity of

any CU trait assessment, since a delinquent's sometimes cool, angry and distant behavior can be easily mislabeled as callous and unemotional.

Limitations and Directions for Future Research

There are several limitations of this study. First, the current sample not only was predominantly female, but also White. Future studies that are able to capture the responses of more diverse participants might be more generalizable to all practitioners and provide insight into the influence of gender and race on practitioners' responses to CU trait clients. For example, since male and female therapists tend to have opposite reactions (females become more involved, males withdraw) when working with clients who trigger unresolved issues (Hayes & Gelso, 1991; Rosenberg & Hayes, 2002), gender differences may surface when working with clients who present with callous and unemotional traits. Similarly, although in this study the race of the hypothetical client was similar to that of most of the study participants, future studies might examine whether or not differences between client and practitioner race impacts practitioner responses to CU traits.

Second, the results of this study not only reflect a hypothetical client, but also one whom the practitioner has only read about. Future research that measures practitioners' responses to either actual or in-person clients not only may be more robust, but also more valid since the Therapist Appraisal Questionnaire was developed and normed on live, interpersonal therapeutic encounters. Third, this study may have been strengthened by incorporating a social desirability index, particularly since there was a discrepancy between practitioners' beliefs about the "influence" of likability and the demonstrated relationship between likability and other study variables. Including a social desirability index would provide a deeper understanding of these findings and also increase their validity. Fourth, since the therapeutic process is bidirectional in

nature, assessing CU trait client responses to and perceptions of the therapeutic process would be worth exploring in future studies in order to better understand how CU trait clients contribute to the relational matrix of therapy (Kiesler, 1982; Levenson, 1995). Last, these results would have been augmented if different/additional methodologies were used. For example, behavioral and cognitive measures for assessing CT and gathering and coding phenomenological data from study participants could allow for a more in-depth and perhaps more comprehensive understanding of how practitioners respond to high CU trait clients.

In sum, mental health practitioners had more negative responses to clients who presented with CU traits than those who did not. They not only experienced fewer positive emotions and were less optimistic about overcoming obstacles when reading about CU trait clients, but also they experienced more negative emotions (anger, disappointment, disgust, sadness, and guilt). Additionally, compared to practitioners who read about a client without CU traits, practitioners who read about CU trait clients indicated that they were less invested in treatment, more likely to refer their client, more likely to negatively appraise some client traits, and did not anticipate therapy would be effective. This study also demonstrated that participants rated CU trait clients as less likable than clients without CU traits. Likability, in turn, also was related to how practitioners interpreted a client description, how invested they were in treatment, their likelihood of referral, and their expectations about therapy effectiveness, all of which could negatively impact the therapy alliance, process and outcome. Further, although there was no difference between practitioners' ratings of intelligence and appearance between the likable and unlikable clients, the results of this study indicate that the unlikable clients had less influence than the likable group on practitioner ratings of intelligence, appearance, treatment investment, and definition of self-confidence. It is hoped that this study will prompt practitioners to examine

and learn from their emotional responses so they can provide optimum treatment to CU trait clients. Importantly, in an effort to establish a therapeutic relationship, practitioners are encouraged to expand their knowledge of CU trait clients so that they might better understand their suffering, cultivate empathy and effectively treat their pain.

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Appendix A

Case Descriptions

The Non-Callous and Unemotional Trait Group (NCU Group)

Mike is a fourteen-year old Caucasian male referred to you for therapy as a result of a recent charge for breaking and entering into a local convenience store and stealing alcohol and cigarettes. His criminal history includes illegal possession of alcohol and vandalism of school property. During the past year, there has been a spike in his school truancy, despite his parents' increased concern and attempts to "reign him in." Mike's family history of mental health issues or alcohol or substance use/abuse is negative; he has an 11-year-old brother and 5-year old sister who are upset by Mike's recent behaviors. According to Mike's parents, Mike met all developmental milestones on time, was a "happy baby" and just recently began to exhibit and engage in delinquent behavior. Mike enjoys basketball, but because of his declining grades, has recently been asked to resign from the JV basketball team. A recent assessment yielded developmentally normative issues of adolescence and placed Mike within the average range for intelligence. Mike reported that he and his friends had been drinking when he broke into the store and that things "clearly went too far and got out of hand." When asked how he might "right this wrong," Mike stated, "well, I feel really bad about messing up that guy's store. Maybe I could fix it up or help out around the store."

The Callous and Unemotional Trait Group (CU Group)

Mike is a fourteen-year old Caucasian male referred to you for therapy as a result of a recent charge for breaking and entering into a local convenience store and stealing alcohol and cigarettes. His criminal history includes illegal possession of alcohol and vandalism of school property. During the past year, there has been a spike in his school truancy, despite his parents' increased concern and attempts to "reign him in." Mike's family history of mental health issues or alcohol or substance use/abuse is negative; he has an 11-year-old brother and 5-year old sister who are upset by Mike's recent behaviors. According to Mike's parents, Mike met all

developmental milestones on time, was a “happy baby” and just recently began to exhibit and engage in delinquent behavior. Mike enjoys basketball, but because of his declining grades, has recently been asked to resign from the JV basketball team. On a recent assessment, Mike scored in the highest range for callous and unemotional traits and within the average range for intelligence. Mike reported that he and his friends broke into the store because “it was a ‘kick’ doing things like that and trashing that old guy’s store.” When asked how he “might right this wrong,” Mike laughed and said, “I dunno, I mean, I don’t get what’s the big deal. The store’s already cleaned up anyway.”

APPENDIX B

Therapist ID:	Session Date:
Client ID:	Session #:

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 therapy session you just conducted with this particular client, rather than on your feelings about therapy in general or any of your other clients.

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

Not at All	Slightly	Somewhat	Moderately	Quite a bit	A Great Deal
0	1	2	3	4	5

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 subscale to which it belongs (C = Challenge, T = Threat, H = Harm). * = reverse-scored item*