

THERAPISTS' EMOTIONAL REACTIONS TO SUBSTANCE ABUSERS: A NEW QUESTIONNAIRE AND INITIAL FINDINGS

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Therapists' emotional responses to substance abuse patients have long been hypothesized to impact on treatment, but have rarely been studied. This article reports results for a new scale developed

for this purpose, Ratings of Emotional Attitudes to Clients by Treaters (REACT). The REACT was administered to 52 therapists and 140 cocaine-dependent outpatients, at sessions 2, 5, and 24 of

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psychotherapy. It was found to have high internal consistency at each time point, moderately high convergent validity with therapists' (but not patients') therapeutic alliance ratings, and a factor structure that appeared to meaningfully derive four factors: "therapist in conflict with self," "therapist focused on own needs," "positive connection," and "therapist in conflict with the patient." Therapists' emotional responses were found to become more negative over the course of treatment, and, when compared by theoretical orientation, were found more positive for 12-step drug counselors than for cognitive or supportive-expressive therapists.

While the therapist is hypothesized to be one of the most important factors in effective psychotherapy for substance abusers (Flores, 1988; Imhof, 1991; Luborsky, Crits-Christoph, McLellan, Woody, Piper, Liberman, Imber, & Pilkonis, 1986; Luborsky, McLellan, Woody, & O'Brien, 1985), there has been relatively little research on this topic (Cartwright, 1981; Imhof, 1991; Imhof, Hirsch, & Terenzi, 1983; Miller, 1985; Najavits & Weiss, 1994; Onken, 1991; Valle, 1981). Some empirical work has documented therapists' influence on treatment outcome and dropout rates, both in the general psychotherapy literature (Crits-Christoph, 1991; Luborsky et al., 1986; Luborsky et al., 1985; Najavits & Strupp, 1994), and with substance abusers in particular (McLellan, Woody, Luborsky, & Goehl, 1988; Najavits & Weiss, 1994; Woody, McLellan, Luborsky, & O'Brien, 1986). Moreover, therapists' influence has been found to occur largely independent of patient characteristics that might be expected to strongly affect outcome (e.g., diagnosis, severity of drug use, sociodemographic status) (Najavits & Weiss, 1994).

However, few therapist factors have been identified that might help to explain differences in therapists' performance. Early work in the substance abuse field attempted to relate therapists' professional characteristics (e.g., paraprofessional versus professional, recovering versus non-recovering) to clinical outcomes. After over 50

studies of this sort, however, no significant differences among such categories of therapists have been found (McLellan et al., 1988). Attempts to identify personality characteristics of substance abuse therapists that might explain differential outcome (Rosenberg, Gerrein, Manohar, & Lifitik, 1976; Snowden & Cotler, 1974; Thrower & Tyler, 1986) have been largely inconsistent; and the use of general personality measures that were not specifically designed to study therapists or therapy limits their relevance. The most consistent finding thus far has been a strong positive association between the interpersonal functioning of therapists (Valle, 1981) and patient outcomes (also called therapists' "helping alliance" (Luborsky et al., 1985) or "accurate empathy" (Miller, Taylor, & West, 1980).

Historically, theoretical works on the treatment of substance abuse have emphasized the importance of therapists' emotional reactions to the patient as a determinant of outcome. Therapists' emotions toward substance abusers are presumed different from their response to other populations: more intense, more negative, and more likely to impact on treatment (see reviews by Imhof, 1991; Imhof et al., 1983). Moreover, the "ideal therapist" for substance abuse patients is typically described in terms of particular constellations of emotions. Miller (1985) asserts that therapist characteristics in alcoholism treatment are "perhaps the most underestimated and least investigated determinants of [patient] motivation" (p. 97). He focuses on three cardinal affects the therapist should possess: a low level of hostility, a high degree of optimism that the patient can get better, and a high degree of empathy. Washton and Stone-Washton (1990) suggest the need for therapists to possess a high degree of empathy, confidence, and hope, and a low wish to control the patient. Other important emotional responses include enjoyment in working with substance abusers (Woody, McLellan, Luborsky, & O'Brien, 1990) and a high degree of patience (Flores, 1988). In exploring reasons for treatment failure of substance abusers, therapists' responses are also emphasized: boredom, cynicism, indifference, blaming, power struggles, withdrawal, burnout, and intense and unstable feelings about the patient (Gustafson, 1991; Imhof et al., 1983; Vannicelli, 1989; Washton & Stone-Washton, 1990; Zweben, 1989).

Only one study has assessed differences in therapists' outcome with substance abusers based on

emotional response. Milmoë, Rosenthal, Blane, Chafetz, and Wolf (1967) determined, based on audiotape ratings, that the more anger and anxiety in doctors' voices during an initial interview, the fewer the patients who followed through on alcoholism treatment. In a relevant study of general psychotherapy patients, Colson and colleagues (Colson, Allen, Coyne, Dexter, Jehl, Mayer, & Spohn, 1986; Colson, 1990) asked 44 professional staff of the Menninger Hospital to rate their affective responses to all 127 inpatients under their care. They found that staff emotional responses varied with patients of particular diagnostic categories. For example, staff most often reported anger toward patients with primary character pathology, hopelessness toward patients with psychotic withdrawal, and protectiveness toward patients with suicidal depression. In addition, some differences in affective response were related professional training, and, in general, more difficult patients evoked a greater variety of emotions in therapists (see also Holmqvist, 1995).

The main goal of this report was thus to explore therapists' emotional reactions to a sample of substance abusers as part of a multisite psychotherapy study. A new measure was developed for this purpose, Ratings of Emotional Attitudes to Clients by Treaters (REACT; Najavits & Colson, 1992). The measure was based in part on the scale used by Colson et al. (1986), but expanded to include variables theorized as most relevant to substance abuse therapists (Najavits & Weiss, 1994). The following specific questions were addressed: (1) What are the basic psychometric characteristics of the REACT (internal consistency, factor structure, and convergent validity with therapeutic alliance measures)? (2) How do therapists respond emotionally to substance abusers? That is, what emotional responses are reported as most and least frequent, and do emotional responses vary based on time point in treatment or theoretical orientation?

Method

Data for this study were collected as part of the NIDA Collaborative Cocaine Treatment Study (NCCTS), a randomized, controlled clinical trial designed to assess the efficacy of three manualized psychosocial treatments for cocaine-dependent outpatients: individual cognitive therapy (CT) (Beck, Wright, Newman, & Liese, 1993), individual supportive-expressive therapy (SE)

(Mark & Luborsky, 1992), and individual 12-step drug counseling (IDC) (Mercer & Woody, 1992). All patients were also offered group 12-step drug counseling (GDC) (Mercer, Carpenter, Daley, Patterson, & Volpicelli, 1994). The NCCTS is being conducted through a cooperative agreement funded by the Treatment Research Branch of the National Institute on Drug Abuse at five collaborating sites: the Massachusetts General Hospital in Boston; McLean Hospital in Belmont, Massachusetts; Brookside Hospital in Nashua, New Hampshire; Western Psychiatric Institute and Clinic in Pittsburgh; and the University of Pennsylvania in Philadelphia, which also served as the coordinating center for the project.

Sample

The sample for this study consisted of 16 cognitive psychotherapists (CTs), 17 supportive-expressive psychotherapists (SETs), 14 individual drug counselors (IDCs), and 5 group drug counselors (GDCs) who were treating patients in the NCCTS. Hereafter, all are referred to as "therapists." SETs and CTs were doctoral-level psychologists, psychiatrists, or master-level social workers; IDCs were addiction counselors with no degree beyond a master's. SETs were required to have at least two years of supervision or training and three years post-graduate experience in psychodynamic therapy. CTs were required to have at least six months of supervised clinical experience in cognitive therapy. IDCs were required to have three years of experience in addiction counseling and to use the 12-step model of addiction counseling. Prior to hire, all therapists were also required to submit audiotapes of at least two treatment sessions for review by the training leaders for the NCCTS, based at the University of Pennsylvania. During the study, all therapists received an hour of weekly individual supervision and were rated by their supervisors on their adherence and competence in delivering the treatment specified in the manual for their particular treatment condition.

The therapist sample was 63.5% ($n = 33$) male and 36.5% ($n = 19$) female. Most therapists (94.2%, $n = 49$) were Caucasian, with 3.8% ($n = 2$) African-American, and 1.9% ($n = 1$) Asian. Therapists currently in recovery represented 19.2% ($n = 10$) of the sample (all for more than three years). Overall, therapists had a mean of 12.9 years of general clinical experience ($sd = 7.4$) and 7.8 years of experience with substance abusers ($sd = 6.4$). They had a mean of

153.1 hours of supervision in the treatment of substance use disorders ($sd = 157.5$).

The patient sample for this study consisted of 140 outpatients who were treated during the pilot phase of the project (June, 1992 through June, 1994), and on whom data were available for this portion of the project. Patients were recruited through newspaper advertisements and community referrals. Inclusion criteria were: diagnosis of DSM-III-R cocaine dependence; age of 18 to 60 years; and use of cocaine in the last thirty days. Exclusion criteria were psychopharmacological or psychosocial treatment outside of the study's protocol; a history of bipolar disorder, schizophrenia, or organic mental disorder; legal mandate to attend treatment; impending incarceration; greater than three months pregnancy; current suicide or homicide risk; life-threatening or unstable illness; hospitalization of greater than 10 days in the past month for cocaine use; homelessness without a long-term shelter; or a plan to leave the area within the next two years. Patients with substance use disorders other than cocaine dependence were included if cocaine was their self-reported primary drug of choice and they did not meet DSM-III-R criteria for current opioid dependence. Substance use disorder diagnoses were assessed at baseline by the Structured Clinical Interview for DSM-III-R (SCID; Spitzer, Williams, & Gibbons, 1987), administered by master's- or doctoral-level diagnosticians. All study diagnosticians were selected, trained, and received biweekly supervision by staff from the Assessment Unit of the University of Pennsylvania Center for Psychotherapy Research.

Patients in the study participated in three phases of treatment: an initial "stabilization" phase (2-5 times per week of individual case management and twice-weekly group drug counseling); randomization to the "active" phase of treatment (6 months of 32 sessions of group drug counseling and 36 sessions of individual treatment, either CT, SE, or IDC); and a "booster" phase (3-6 sessions for maintenance of gains in treatment). Three consecutive urine samples clean of all substances of abuse were required for randomization to the "active" phase of treatment. All treatment was provided free to patients; therapists were paid for their work.

Of the 140 patients in the study, 59% ($n = 84$) were Caucasian, 36% ($n = 50$) were African-American, 4% ($n = 5$) were Hispanic, and 1% ($n = 1$) was Cape Verdean. Sixty-five percent ($n =$

91) were male and 35% ($n = 49$) were female. Fifty-four percent ($n = 76$) were employed, 37% ($n = 51$) were unemployed, 5% ($n = 7$) were unemployed with other constructive activity (student or homemaker), and 3% ($n = 4$) were on disability of some kind (2 patients, 1%, did not report employment status). Of the 140 patients, primary method of use was described by 72% ($n = 101$) as smoking "crack" cocaine, 24% ($n = 34$) as nasal ingestion, with 1% ($n = 2$) injecting cocaine; the remaining three patients, 2%, did not report method of use. The patients had used cocaine a mean number of 8.5 days in the month before their intake assessment ($sd = 7.4$). REACT data were available for 100 patients at session 2, 87 at session 5, and 55 at session 24.

Instruments

The primary measures were as follows:

Rating of Emotional Attitudes to Clients by Therapists (REACT). The REACT (Najavits & Colson, 1992) is a 40-item self-report measure in which therapists rate their emotional responses to each patient on a 0 to 6 scale. The measure is based in part on a scale previously developed and tested at the Menninger Foundation by Colson et al. (1986) but was modified for this study to include variables more directly relevant to substance abusers, based on a literature review (Najavits & Weiss, 1994). The instrument takes about five minutes to complete, and was administered at three time points: after the second, fifth, and 24th sessions of treatment. These sessions were chosen to provide test-retest information (i.e., second to fifth session data); as well as across the length of treatment (24th session).

The Helping Alliance questionnaire (HAQ-II). The HAQ-II (Luborsky et al., in press) is a 19-item self-report questionnaire assessing therapeutic alliance on a 6-point scale, with identical versions rated by the patient and the therapist. This instrument was selected for the current study as it assesses a well-known theoretical construct that has been repeatedly found predictive of therapy outcome, and might be expected to relate to therapists' emotional reactions to patients. The instrument shows high internal consistency (above .90 for both patient and therapist versions at sessions 2, 5, and 24), moderately strong test-retest reliability (.79 on the patient version and .57 on the therapist version), and moderate to high convergent validity with the California Psychotherapy Alliance Scale (CALPAS) total score at sessions

2, 5, and 24 (.60 or above for the patient version and .75 or above for the therapist version) (Luborsky et al., in press).

The California Psychotherapy Alliance Scale (CALPAS). The CALPAS (Gaston & Marmar, 1994) was included as an additional measure of therapeutic alliance. The scale consists of 24 self-report items, rated on a 7-point scale, with identical versions rated by the patient and the therapist. It is made up of four subscales: Patient Working Capacity, Patient Commitment, Therapist Understanding and Involvement, and Working Strategy Consensus.

Analyses

(1) *Psychometric characteristics of the REACT.* The internal consistency of the REACT was assessed by Cronbach's alpha. Two subscales ("positive feelings" and "negative feelings") were rationally defined a priori based on a clear direction of the items, and consisted of 12 and 23 items respectively. In addition, a principal components factor analysis with varimax rotation was used to identify possible empirically-based subscales of the measure. To explore the relationship between the REACT and therapeutic alliance measures, two-tailed Pearson correlations were conducted using the means of each measure (with the REACT calculated as the mean of all 35 "positive-feeling" and "negative-feeling" items, with reverse scoring of the latter).

(2) *Therapists' emotional responses to patients.* Descriptive statistics were calculated per REACT item to describe therapists' most and least common emotional responses, and a repeated measures ANOVA was conducted to study change over time (sessions 2, 5, and 24). ANOVA and the post-hoc test of least significant differences were used to compare responses on the REACT by the three different theoretical orientations of the individual treatments (SE, CT, IDC). This analysis was conducted at session 5 only, chosen as the point where treatment was well underway and the most data were available.

While multiple regression analyses would have been preferable to the use of *t*-tests and correlations, sampling differences and missing data over time precluded the use of those. Repeated measures ANOVA was used to the extent possible.

Results

Psychometric Properties of the REACT

Internal consistency. The internal consistency of the REACT (using all complete data forms

available at each time point) was found to be consistently high. Cronbach's standardized item alphas were: session 2, .82 ($n = 38$ therapists and 75 patients); session 5, .80 ($n = 36$ therapists and 71 patients); and session 24, .81 ($n = 29$ therapists and 45 patients).

Factor analysis. To identify possible empirically-based subscales of the REACT, an exploratory factor analysis was performed, again using all complete forms available at each timepoint, with the same *n*'s as reported in the previous paragraph. Initially, 4, 5, and 6 factor solutions were conducted for each of sessions 2, 5, and 24. Results were relatively consistent over time. We report the session 5, four-factor solution as it was far enough into treatment to be considered representative of the therapy yet early enough to capture a large segment of the available subjects. Also, the four-factor solution offered the most meaningful interpretation while accounting for a relatively high proportion of the variance (52%). (See Table 1).

The four factors (and percentage of the variance accounted for by each), might be labeled as "therapist in conflict with self" (28.9%), "therapist focused on own needs" (10.7%), "positive connection to the patient" (7.2%), and "therapist in conflict with patient" (5%).

Relationship to therapeutic alliance measures. The REACT total score was correlated with the two alliance measures (HAq-II and CALPAS) at three time points. Results showed moderately strong correlations with the therapist versions of the instruments, and lower correlations with the patient versions. Significant results for the therapist versions were, specifically: session 2, .60 with the CALPAS ($n = 98, p < .0005$) and .53 with the HAq-II ($n = 98, p < .0005$); session 5, .62 with the CALPAS ($n = 84, p < .0005$) and .58 with the HAq-II ($n = 86, p < .0005$); session 24, .60 with the CALPAS ($n = 52, p < .0005$) and .73 with the HAq-II ($n = 52, p < .0005$). For patient versions, significant results were: session 2, .21 with the CALPAS ($n = 98, p = .037$); and session 5, .33 with the CALPAS ($n = 84, p = .002$).

In addition, factor scores from the factor analysis above were correlated with the therapeutic alliance measures at session 5. We were particularly interested in the factor labeled "positive connection," which was found to have low to moderate correlation with the therapeutic alliance measures (.47 with the CALPAS therapist score, $n = 68, p < .000$;

TABLE 1. Factor Analysis of the REACT

| REACT item | Factor loadings (and percent variance) | | | |
|--|---|---------------------------------------|---------------------------------------|--|
| | 1 "In conflict with self" (29%) | 2 "Focus on own needs" (11%) | 3 "Positive connection" (7%) | 4 "In conflict with patient" (5%) |
| Doubting my competence | .69 | | | |
| Satisfied with my therapeutic efforts | -.68 | | | |
| Thought about patient outside of sessions | .64 | | | |
| Overwhelmed by severity of patient | .63 | | | |
| Worried about the patient | .63 | | | |
| Stressed working with patient | .60 | | | |
| Optimistic about patient's future | -.59 | | | |
| Gratified about my work with the patient | -.58 | | | |
| Confused about the patient | .56 | | | |
| Frustrated | .52 | | | |
| Disappointed with patient or the treatment | .51 | | | |
| "Burned out" with this patient | | .77 | | |
| Drained and exhausted | | .75 | | |
| Insufficiently paid (financially) on this case | | .63 | | |
| A sense of overinvolvement ("stickiness") with the patient | | .62 | | |
| Provoked or angered by the patient | | .55 | | |
| Wishing to withdraw from contact with the patient | | .55 | | |
| Bored with the patient | | .52 | | |
| Enjoyment with the patient | | | .82 | |
| A sense of connection or attachment to the patient | | | .81 | |
| Liking, fondness, affect for the patient | | | .72 | |
| Empathy, sympathy, or compassion | | | .70 | |
| Tolerant and understanding | | | .61 | |
| Appreciated by the patient | | | .58 | |
| Cautious/uneasy confronting or setting limits with patient | | | | .73 |
| Manipulated or used by the patient | | | | .65 |
| Power struggles with this patient | | | | .60 |
| Helpless in relation to the patient | | | | .54 |

Note.—All factor loadings of .50 or greater are listed. Items 1-38 were included in the factor analysis; item 39 ("had dreams about the patient") was omitted due to lack of variance and item 40 was omitted because it referred to write-in responses of "other emotions."

.27 with the HAQ therapist score, $n = 70$, $p = .03$; and .23 with the CALPAS patient score, $n = 68$, $p = .057$). Significant results for the other subscales were in the expected directions, with the "negative" subscales ("therapist in conflict with self" and "therapist in conflict with patient") negatively correlated with the alliance therapist scores (ranging from $-.33$ to $-.42$).

Use of "can't say" responses. We also tallied the number of "can't say" responses to determine whether therapists felt able to answer each of the items without difficulty. Out of 287 questionnaires only 67 (.0001%) of the responses were "can't say." Also, the number of "can't say" re-

sponses was not found to change over time, nor to vary by treatment condition.

Therapists' Emotional Responses to Cocaine Dependent Outpatients

Therapists' responses, overall. Therapists consistently endorsed positive feelings more than negative feelings, at all three timepoints. Ratings of negative feelings were generally very low (rarely above 2, "seldom"). Ratings of positive feelings were somewhat higher (generally between 3, "sometimes," and 4, "often"). As an example of typical responses, at session 5 the three most prominent reactions were: "tolerant

and understanding" ($x = 4.0$, $sd = .8$, $n = 87$); "empathy, sympathy, or compassion" ($x = 3.8$, $sd = .8$, $n = 86$); and "satisfied with your therapeutic efforts with this patient" ($x = 3.7$, $sd = .8$, $n = 87$). The three least endorsed items were: "had dreams about the patient" ($x = 1.0$, $sd = 0$, $n = 84$); "sexual attraction for this patient" ($x = 1.1$, $sd = .4$, $n = 85$); and "strong dislike or hate toward this patient" ($x = 1.1$, $sd = .4$, $n = 85$). Also, therapists rarely added in any additional feelings not already listed on the questionnaire (item 40), and standard deviations for all items were low (ranging from 0 to 1.1), indicating therapists' similarity in responses. The most and least prominent responses remained largely consistent at each time point.

Change over time. To study change over time on the REACT, a repeated measures ANOVA was conducted on the subsample of patients for whom data was available for each of sessions, 2, 5, and 24 ($n = 18$ therapists and 29-31 patients). Nine items (out of 39 possible) were significant at $p < .05$ based on post-hoc tests. Most of these indicated greater negative feelings over time: "confused," and "bored" (increase from session 2 to 5); "burned out," "frustrated," "helpless," "disappointed," "bored" (increase from session 2 to 24). Two items denoted more positive feelings over time: "appreciated" and "fondness, affection" (increase from both sessions 2 and 5 to 24). One item was ambiguous: "thought about patient outside of session" (increase from both sessions 2 and 5 to 24).

Results by theoretical orientation. This analysis was conducted for session 5 data only ($n = 13$ therapists per orientation). First, individual REACT items were analyzed ($n = 75$ to 77 patients). Significant results were found for 22 REACT items (out of 39 possible) at $p < .05$, with a breakdown as follows. Psychotherapists (SET and CT) consistently reported stronger negative feelings than did drug counselors (IDC) (8 items); and, vice versa, drug counselors reported more positive feelings than did the psychotherapists (4 items). In addition, SETs reported the most negative feelings of the three conditions (9 items in which SETs were higher than CT, IDC, or both). The only unique finding for CT therapists was their higher endorsement for feeling "intellectually stimulated" compared to the other conditions.

REACT factor scores and subscales were also compared by theoretical orientation ($n = 64-76$

patients), with findings similar to those above. Significant results were found for 3 (out of 6 possible) at $p < .05$. The two psychotherapies (SET and CT) showed greater "conflict with self" than did IDC. SETs reported greater "conflict with the patient" than did the other conditions. They also endorsed more "negative feelings" than did CTs, who in turn were higher than IDCs.

Discussion

This report provides empirical study of an area long theorized to be important in substance abuse treatment, but virtually unstudied: therapists' emotional responses to their patients. It is the only known study that has systematically evaluated therapist responses using an extensive scale based on theoretical writings; that has studied therapist response in relation to change over time and theoretical orientation; and that has evaluated therapist responses in relation to a rigorously diagnosed, homogeneous patient sample (cocaine dependent outpatients participating in a randomized, controlled clinical trial).

Our first effort, to explore basic psychometric characteristics of the REACT, showed the instrument to have high internal consistency, moderately high convergent validity with therapists' therapeutic alliance ratings, and a factor structure that appeared meaningful and relatively stable over time. The factor structure is particularly interesting in that three of the four factors appeared to represent negative emotional struggles to which therapists may be prone in working with substance abusers. The factors identified were: conflict with oneself over the degree to which one is performing therapy adequately (e.g., feeling confusion and stress, and doubting one's competence), conflict with the patient (e.g., power struggles, feeling manipulated), and a focus on meeting one's own personal needs (e.g., for financial, sexual, or intellectual gratification). A fourth factor contained only positive items (e.g., feelings of empathy, tolerance, and affection). Correlations of this factor with known alliance measures, which might be presumed to be strong, were only moderate in strength. This might suggest that the REACT "positive connection" subscale is tapping therapists' internal feelings about their patients, rather than measuring their working relationship with the patient *per se*. The low correlation between the total REACT score and patient alliance ratings was also interesting, perhaps indicating that therapist internal

emotional reactions are largely hidden from the patient's view.

One of the most intriguing findings of the study was that psychotherapists in general, and SET therapists in particular, consistently endorsed more negative feelings than did 12-step drug counselors (IDC). Whether this represents greater awareness of difficult countertransferential responses, greater difficulty treating substance abusers, consistency with the philosophies of the respective orientations, or a bias in willingness to report negative feelings remains unknown. It may also reflect the fact that IDCs chose a career working with substance abusers while therapists typically did not. Alternatively, it may represent a hiring bias, as therapists for each condition were selected by different staff. It can be noted, however, that for the sample as a whole, negative feelings in general increased over time more than did positive feelings, and accounted for more variance in the factor analysis than did positive feelings. These findings are consistent with the theoretical psychotherapy literature, which posits that negative feelings toward substance abusers are very common. Therapists' willingness to report difficult feelings, including concerns about money, sexual attraction to patients, and power struggles, was encouraging in suggesting that therapists, at least in this sample, are perhaps able to be conscious of their reactions and willing to report them. Our therapists may be unusual, however, in that all of their sessions are taped and they underwent a very careful selection, training, and supervision process that may have made them more willing to be scrutinized and to report difficult experiences.

The degree to which positive feelings were present also should not be ignored. They were in fact the most prevalent responses endorsed at any one time. This suggests that therapists are capable of strong empathic, caring feelings for these patients—which is not to be taken for granted in a literature that points to a bias against substance abusers as an underclass who is often perceived as unappealing to work with. The degree to which therapist ratings were determined by patient characteristics (e.g., severity or difficulty) or even by supervisor characteristics (e.g., greater or lesser emphasis on noticing negative therapist responses) remains unclear as well.

All of our results, however, must be interpreted in light of the limitations of this study. Problems of missing data, attrition of subjects over time,

the relatively low sample sizes available for factor analyses, the use of numerous *t*-tests (which may inflate Type 1 error rates), and the absence of a consistent therapist/patient sample across sessions all suggest a clear need for replication of findings through future research. Exploration of results across a variety of therapist and patient samples would also be informative. Analyses in terms of each therapist caseload may be especially valuable, as in Luborsky et al. (1985) and Najavits and Strupp (1994).

The findings of this study, taken as a whole, argue for further work in this area. The bottom-line question of future research must, of course, be the relationship of therapists' emotional responses to their objective outcomes with patients (e.g., retention in treatment, urinalysis results, and standardized psychological outcome scores). As yet unclear is the extent to which endorsement of positive or negative items relates to effectiveness with patients. An argument could be made either way. Therapists who are more aware of their own negative feelings may be more likely to relate genuinely and realistically to a difficult patient population. Conversely, negative feelings may interfere with effective treatment. An admixture is also possible: there may be some still-to-be-discovered optimal balance of positive and negative feelings that might predict good outcome, with a simple linear metric too narrow a model. An ideal range of affect may also be desirable, above or below which emotional reaction interferes with treatment. For example, extremes of identification or nurturance toward a patient may well indicate the therapist's own needs being placed above those of the patient. Various other provocative findings of this study must also eventually be understood in light of actual outcomes: for example, therapists' satisfaction and self-rated effectiveness, the themes of internal struggle identified in the factor analysis, the increase in negative feelings over time, and the influence of theoretical orientation.

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