

ORIGINAL ARTICLE

Therapist reactions in self-experienced difficult situations: An exploration

ANNEMARIE J. M. SMITH¹, WIM CHR. KLEIJN^{1,2}, & GIEL J. M. HUTSCHEMAEKERS^{3,4}

¹Centrum'45, Rijnzichtweg 35, 2342 AX Oegstgeest, The Netherlands, ²Leiden University Medical Center, Medical Psychology, Leiden, the Netherlands, ³Radboud University Nijmegen, Academic Centre for Social Sciences, Nijmegen, The Netherlands, and ⁴GRIP, Gelderse Roos Institute for Professionalization Research, Wolfheze, the Netherlands

Abstract

This article describes a qualitative study of 63 difficult therapeutic situations described by 26 therapists. The study was part of research on specific reactions of therapists to traumatized clients. The research questions for the current analyses focused on the categorization of difficult situations, of short-term therapist reactions, and the exploration of situation-specific reaction patterns. The therapeutic style of the therapist was also explored. Three types of difficult situations were found: 'traumatic situations', 'interactional situations' and 'existential situations'. Therapist reactions were sorted into 20 categories; 10 of them were part of a situation-specific pattern. The therapeutic style of therapists was defined by a first dimension reflecting a continuum of experiencing versus actively intervening and a second dimension of feeling responsible. The relevance for therapist self-reflection, supervision and training is to acknowledge the specific difficulties in different therapeutic situations related to therapist-specific reactions, and to enhance constructive coping in accordance with the therapist's therapeutic style.

Keywords: *Therapist difficulties, countertransference, traumatic countertransference, therapeutic style, supervision*

Introduction

Psychotherapy is an intense intersubjective process for the client but certainly also for the therapist (Hoyt, 2001; Kantrowitz, 1997). Strong emotions, as evoked by traumatic material, may strain the empathic ability of the therapist (Wilson & Lindy, 1994). An important task of the therapist is to differentiate their own contribution from the client's in order to understand the dynamics of the interaction (Gabbard, 1995; Kiesler, 2001; Davis et al., 1987) and handle the therapeutic relationship. This double position of experiencing participant and responsible therapist makes the psychotherapeutic profession such a challenging one, drawing on insight and skills. Therefore, continuous reflection on the therapist's own contribution in the therapeutic relation is a requisite for proper professional conduct. Research should aim to facilitate this process by empirically supported conceptualizations of therapists' reactions.

Within the psychoanalytic tradition, 'countertransference' describes the influence of therapists' own unresolved issues on the dynamics of therapy. Hayes (1998; 2004) based his structural theory of countertransference on a qualitative study, distinguishing origins, triggers, manifestations, effects and management of countertransference. Empirical studies are, however, still scarce and flawed (Fauth, 2006). Other

therapeutic orientations have their own terms to describe 'countertransference' (Hoyt, 2001; Brown, 2001; Mahrer, 2001). Interpersonal psychotherapy research differentiates subjective countertransference referring to therapist issues and objective countertransference that is related to problematic interpersonal patterns of the client (Kiesler, 2001; Holmqvist & Armelius, 1996b). Differences in clients' problems seem to influence patterns of therapist reactions (Holmqvist & Armelius, 1996b; Schwartz & Wendling, 2003; Dube & Normandin, 1999; Brody & Farber, 1996), although therapists show great consistency of feeling patterns across different clients (Holmqvist, 2001). These studies emphasize the importance of therapist issues, client factors and therapists' personal style, but research on "the various therapist baselines needed to interpret a particular therapist deviation" (Kiesler, 2001, p. 1062) is virtually absent.

An early study on patterns of therapist experiences is presented by Davis et al. (1987). They developed a taxonomy of therapist difficulties that was used in a large international study on the development of psychotherapists (Orlinsky & Rønnestad, 2005). Two of the three underlying dimensions of the 10 types of therapist difficulties focus on the therapist's experience ('professional self-doubt' and 'negative personal reaction'). The third dimension, 'frustrating

What does this study explore?

- Psychotherapists' reactions to difficult situations with clients
- Situation-specific therapist reaction patterns above therapists' personal style
- Clinically relevant dimensions of personal therapeutic style of the therapist

treatment case', emphasizes the client's situation or therapist dilemmas. Schröder and Davis (2004) identified three kinds of difficulties in a study of therapists' self-reported difficult situations. They differentiated 1) transient difficulties, related to gaps in knowledge or experience of the therapist; 2) paradigmatic difficulties, based on personality characteristics or personal conflicts of the therapist; and 3) situational difficulties, which were independent of the therapist's personality or experience but related to intrinsic characteristics of the situation. This taxonomy is relevant for the supervision situation because it identifies different needs of the therapist as skills training, personal therapy or support. Both studies stress the independent influence of situational factors, which raises questions about the nature of these situations and possibly situation-specific reaction patterns.

The trauma literature is more explicit about specific effects of the confrontation with (traumatic experiences of) the client (Herman, 1992; Pearlman & Saakvitne, 1995; Wilson & Lindy, 1994). Danieli (1984) showed the existence of specific counter-transference themes in the treatment of Holocaust survivors. Holmqvist and Andersen (2003) found that therapists of torture victims felt less motherly, objective and enthusiastic, and more anxious and cautious than did therapists of clients with other problems. Smith et al. (2000) found that trauma therapists reported fewer negative emotions but felt more responsible than did (non-specialized) client-centred therapists. The confrontation with traumatic material could also result in posttraumatic symptoms (Secondary traumatization, Figley, 1995), and the accumulation of confrontations with (interpersonal) violence could lead to distortions of the therapist's cognitive schemas (Vicarious Traumatization, McCann & Pearlman, 1990). However, Sabin-Farrell and Turpin (2003) concluded that, in contrast to clinical reports, there is insufficient empirical evidence for these effects and their specific relation to trauma-work. Overlapping definitions and a lack of validated instruments make conclusions hazardous and only a few studies compared traumatic and other difficult situations (Schwartz & Wendling, 2003).

Some therapeutic situations are clearly difficult, independent of the therapist's personal issues, experience or skills. Identification of 'normal' situation-specific therapist reactions could help therapists to seek proper support in dealing with them in a professionally adequate way. So, how specific are

reactions of psychotherapists toward different therapeutic situations? Do traumatic situations evoke different reactions than other therapeutic situations and is it possible to differentiate situation-specific reaction patterns from therapist-specific baseline patterns? The research questions we address in this study are: 1) which situations do therapists experience as difficult?; 2) how do they react in these situations?; 3) do situation-specific reaction patterns exist, and what is their content?; and 4) how does personal therapeutic style influence therapists' reactions to clients?

Method

In this study, we combined and re-analyzed data from two previous studies. The first study was an exploration of work-stress and specific trauma-related effects in trauma-therapists working in a specialized treatment centre for victims of organized violence (Smith et al., 2000, 2001). The second study explored differences between expert-therapists with regard to the trauma-specificity of reactions to difficult therapeutic situations and long-term effects of psychotherapeutic work (Smith et al., submitted).

Participants

In the first study, fifteen therapists were interviewed. The selection was based on representation of therapists of different professional backgrounds and length of work experience at the trauma-institute. In the second study, eleven experienced psychotherapists were interviewed: five trauma-therapists were compared to six therapists in regular psychotherapeutic practice and no special experience with traumatized clients. All participants were known as experts in their specialization. They could reflect on their long-time career, while still being actively involved in clinical work and supervision. Table I shows the main demographic characteristics of the two samples.

Procedure

To ensure the privacy of the participants in the first sample (all worked in the same institute as the main researcher), interviews were conducted by an external interviewer. Transcripts were anonymized by omitting explicit references to gender and to specifics of the work setting, before they were made available to the researcher. The first author conducted the other interviews (study 2). Transcripts were presented to the participants for agreement.

Interviews started with an open question to describe a self-experienced difficult situation with a client. The initial answer was followed by explorative questions: what happened, what did you feel, what did you do, how did you try to cope, what were the results, what triggered your reaction in the first place and what part of your reaction could be attributed to client factors or to therapist factors?

Table I. Demographics of trauma-institute therapists and expert-therapists.

	Trauma-institute	Expert-therapists
Age		
30–39 yrs.	5	
40–49	6	
50+	4	11
Experience		
0–2 yrs.	4	
3–5	5	
5+	6	
20+		11
Professional background/therapeutic frame of reference	psychiatrist, psychotherapist and art-therapist (11), milieu therapist (4)	psychiatrist (6)/psychologist (5) psychoanalytic (4) client-centered (4) CBT (2) systems therapy (1)
Work setting		
mental health institute		2
academic	15	6
private practice		3
Trauma specialization		
yes	15	5
no		6

The interviews lasted about 60–90 minutes and were audio taped. An extensive, almost verbatim transcript was used for subsequent analyses.

Analysis

For the purpose of this paper we first analyzed the transcripts of the expert-interviews (study 2) according to the first steps of a grounded theory analysis (McLeod, 2003), resulting in categories of difficult situations and therapist reactions.

Secondly, we used these categories of difficult situations and therapist reactions (transformed into a checklist) to quantify the data. Initially, the qualitative material of both studies was combined. Thereafter, we scored situation-type and therapist reactions in each separate difficult situation (situation-bound dataset). Next, the same reactions-checklist was used to score each participant's entire interview, resulting in a second, therapist-bound dataset. The quantification enabled frequency analyses of therapist reactions and Multiple Correspondence Analysis (SPSS) to explore therapist reaction patterns and clusters of reactions.¹

Multiple Correspondence Analysis can be viewed as a principal components analysis of nominal data. Results can be given in two or more dimensions that can be interpreted using the factor-loadings of the variables. Further, plots are generated in which individual reaction-categories that are frequently mentioned together can be identified as clusters. Finally, participants that share relatively many aspects are plotted close to each other and participants with relatively few common aspects much further apart.

This makes it possible to check for possible confounding participants' characteristics.

Results

Difficult situations

The 15 trauma-institute therapists produced 27 analyzable difficult situations with clients. The 11 expert-therapists described 36 self-experienced difficult situations with clients. We predefined a category 'traumatic situations'. The description by the therapist had to include features of clients' experiences that suited the DSM-IV A-criterion for posttraumatic stress disorder: a threat to the physical or psychological integrity of the person, accompanied by intense feelings of anxiety, helplessness and anger. The other situations were categorized according to similarity of thematic content into interactional difficulties and existentially difficult situations. 'Interactional difficulties' were situations in which the client's verbal or nonverbal behaviour exerted a strong interactional appeal to the therapist. In existentially difficult situations, the actual situation of the client was difficult to handle for the therapist, without an interactional pressure from the client.

To illustrate the difficulties described by the participants and their attempts to differentiate between situations we give a few fragments from the interviews:

"Suddenly I remembered the first client that I saw with an incest history, the day that she told me about it, and that was a very powerful experience. It was the first time and I was rather blown away by it. I had several rather weird experiences. I had a

¹ A detailed description of the method of analysis is available on request to the first author.

positive dissociative experience in the room with the client. And afterwards when my client left I went out in the hallway, and my supervisor, who had been watching behind the one-way mirror, patted me on the back and said 'we all have this happening to us sometime. Every therapist has this experience at the first time he meets clients that are really severely sexually abused. It is a rite of passage'. She recognized that I had been deeply affected by this." (experts, traumatic)

"I worked with a new group and we evaluated the therapy with the group. And then it turned out that they wanted more, it's never enough, they want more therapy, more insight, more working through... That dependent attitude, those reproaches, like you cannot make me happy, so you are not ok, that is what they convey. I felt something like I have nothing to offer, I cannot do it, but also frustration, anger... if they have different wishes they should look elsewhere... I talked about it and let it sink. Afterwards I understood that this is what traumatized clients can do, this kind of appeal. They ask for acknowledgement of their victimization." (trauma-institute, interactional)

"You try a lot, and it seems to work, but at the same time you know that whatever you do, it has limited effect, because they have concerns about housing, status, their family... Of course they have their trauma history, but the other factors are thus important that you wonder what you are doing. When they are ready to go, they encounter all these other problems... That is frustrating, absurd..." (trauma-institute, existential)

Only a minority of the trauma-institute therapists focused on traumatic experiences of their clients. The 15 trauma-institute therapists described 9 'traumatic' situations, 15 'interactional' and 3 'existential' situations. The 11 expert-psychotherapists described 20 'traumatic' situations, 9 'interactional' and 7 'existential' situations. The expert-therapists who were not specialized in trauma-treatment described 8 traumatic situations, the other subgroup of expert trauma-therapists 12. The total number of difficult situations described by the 26 participants in both studies was 63.

Therapist reactions

The qualitative analysis of the transcripts of the expert interviews resulted in 20 categories of therapist reactions that are described in Table II. These categories were used to quantify the data of the difficult situations by scoring therapist reactions in each situation.

Table II presents the prevalence of therapist reactions for the trauma-institute group (Sit1) and the expert group (Sit2). 'Advice', 'Avoidance', 'Fascination', 'Distancing', 'Sorrow', 'Limit Setting' and 'Intrusion' were reported infrequently. These categories are not included in the explorative analysis of clusters of therapist reactions in difficult situations.

Situation-specific reaction patterns

The remaining 13 reaction categories and 3 situation types were entered in the Multiple Correspondence Analysis. Each situation type was related to a cluster of reaction categories. Traumatic situations were

Table II. Categories of therapist reactions and frequencies of reactions in difficult situations (Sit1 and Sit2) and in the complete interview (Th1 and Th2).

Content or description of statements	Category label	Sit1 ^a N = 27 (%)	Sit2 N = 36 (%)	Th1 N = 15 (%)	Th2 N = 11 (%)
Anxiety / existential threat felt by the therapist	Anxiety	30	58	53	91
Being carried away by the intense feelings of the client	Sympathizing	33	58	47	82
Shock / confusion	Shock	30	56	40	100
Helplessness	Helplessness	56	47	80	82
Investing emotionally more than usual / taking the lead and becoming tired	Investment	48	25	67	54
Provoked feelings or behaviour (by the client or his/her narrative)	Provoked	44	36	87	82
Feeling too much responsibility for the client or the therapeutic process	Responsible	33	31	60	45
Disgust / nausea / tenseness / unrest	Somatic	26	33	60	45
Active attitude and interventions / being more outreaching than usual	Active	56	17	80	45
Needing to talk to others for self-reflection or catharsis	Talking	37	22	60	82
Irritation / anger / aggression	Anger	33	17	67	54
Ruminating / not being able to let go after the session	Rumination	26	22	47	91
Consciously regulating therapist empathy level	Regulation	22	25	33	73
Seeking advice (from colleagues)	Advise	26	11	60	45
Avoidance of the client / being relieved with missed appointments	Avoidance	22	22	40	64
Fascination / challenge	Fascination	15	22	47	64
Not being able to empathize / feeling a great distance	Distance	15	19	33	36
Sorrow	Sorrow	7	19	20	54
Setting limits for the client	Limit setting	7	14	20	45
Intrusive images / nightmares / dreams	Intrusion	4	17	7	82

^aIf frequency ≥25%, the category is defined as a possible situation-discriminating variable (in bold).

related to 'Shock', 'Anxiety', 'Sympathizing', 'Somatic reactions' and 'Talking'. In interactional situations therapists typically reported 'Provoked feelings or behaviour', 'Helplessness', and 'Investment'. Existential situations were related to 'Responsible' and 'Ruminating'. The categories 'Anger' and 'Active' tended to be associated with interactional situations, 'Regulating empathy' with traumatic situations.

There were no systematic differences between the two samples or between the trauma-experts or other psychotherapy experts with regard to their patterns of situation-bound reactions.

Therapeutic style

Therapeutic style is defined as the preferred reaction tendency of a therapist, which is relatively independent of a specific therapeutic situation. To extract therapist-related data from the original interviews, we scored every reaction category once (present or not present) for each of the 26 therapists.

The columns Th1 and Th2 in Table II present the percentages of therapists that mentioned a certain reaction. A large majority of therapists endorsed 'Helplessness' and 'Provoked feelings and behaviour'. Expert-therapists reported more often intrusions, shock, anxiety, being carried away by intense feelings, ruminating and regulating empathy. The trauma-institute group tended to more active in-session behaviour.

To explore therapeutic style, we executed a Multiple Correspondence Analysis on these therapist-related data. In the two-dimensional solution, the categories 'Intrusions', 'Shock', 'Ruminating' and 'Anxiety' dominated the first dimension, with 'Active' on the other end of the continuum. 'Seeking Advice' and 'Responsible' were the main categories on the second dimension. The therapist's therapeutic style is characterized by her position on these two dimensions. Within this dimensional structure, five reaction clusters described stylistic patterns of the participants. A first reaction cluster represented strong personal experiences: 'Intrusions', 'Anxiety', 'Sorrow' and 'Sympathizing'. A second cluster featured interpersonal reactions: 'Anger', 'Helplessness', 'Fascination' and 'Provoked', combined with 'Somatic' and 'Avoidance'. The third cluster contained coping strategies like 'Regulating empathy', 'Ruminating' and 'Talking'; 'Shock' was also linked to this cluster. A fourth cluster represented interpersonal coping strategies: 'Active interventions', 'Investment', 'Limit setting' or 'Distancing'. The fifth cluster featured 'Responsible', 'Advice' and 'Investment'.

There were no differences between the subsamples on the Responsible dimension, but the trauma-institute therapists tended to more active interventions than the experts did.

Discussion

In this study, we explored therapist reaction patterns in difficult therapeutic situations and personal style of the therapist.

We identified three types of difficult situations: traumatic, interactional and existential situations. Although they are not mutually exclusive, each was related to a specific reaction pattern. Traumatic situations evoked shock and anxiety. Therapists felt overwhelmed and destabilized, of which the need to talk may be a sign. In interactionally difficult situations, therapists felt helpless and provoked or manipulated by the client, and they invested emotionally more than usual. In situations that were characterized by existential problems of the client or dilemmas of the therapist, therapists felt very responsible for the client or the therapeutic process. They tended to keep ruminating after the session. These reaction patterns were superposed on the therapist's personal therapeutic style. The first of the two style-dimensions represented the tendency of therapists to intervene actively in relation with the client. Therapists who are low on this keep their feelings more to themselves and their coping aims to unburden and control their own feelings rather than to control the client. The second dimension represented a continuum of responsibility: the more responsible therapists feel for their clients or the therapeutic process, the more they focus on coping behaviour instead of feelings.

These results should be interpreted with regard of the limitations of the study. The differences in context of the two studies may have influenced the data. The first study focused on dealing with stress of trauma-work, the expert-study intended conceptual clarification. Each sample was relatively small and not representative for trauma-therapists in study 1, or for psychotherapists in study 2. The similar approach in the interviews made it possible to combine both studies for the analysis of the quantified data. The main researcher's work experience was in trauma-therapy and she was well informed about discussions on trauma-specific therapist reactions. Therefore, special attention was given to bracketing researcher's assumptions. This was facilitated by the use of Multiple Correspondence Analysis, but subjective influences on the interpretation of the results cannot be ruled out. The results should be tested in a design with adequate statistical power to test specific hypotheses. Despite these limitations, our preliminary results add to existing research and may alert therapists to situation-specific reactions and help them reflect on their personal therapeutic style.

With respect to countertransference research, some differences are noticeable between our reaction categories and those found in other qualitative studies (Hayes et al., 1998; Richards, 2000; Liffé & Steed, 2000). More prominent in our material were intrusions, shock, and somatic reactions, possibly related

What does this study tell us?

- Psychotherapists encounter difficult clinical situations throughout their career
- The confrontation with clients' traumatic experiences evoke a situation-specific reaction pattern characterized by shock, anxiety, being carried away by strong feelings of the client, somatic reactions and the need to talk about the experience
- Therapists' personal therapeutic style can be described by their preference for an experiencing versus an actively intervening attitude, and by the extent to which they tend to feel responsible for the client or the therapeutic process
- The acknowledgement of situation-specific reaction patterns and the recognition of one's personal therapeutic style may help therapists to cope with therapeutic difficulties, as well as with the inherent stresses of psychotherapeutic work

to the high intensity of the situations described by our participants and the number of traumatic situations. However, shame and guilt were almost absent in the narratives of our participants. This is discordant with results of other research where shame and guilt were important therapist reactions in relation to traumatized clients (Hahn, 2000; Danieli, 1988). Could this reflect the 'conspiracy of silence' about trauma (Danieli, 1984) or parallel the dynamics of shame in a supervision situation (Yourman, 2003)?

The typology of difficult situations was defined by presenting problem, instead of therapist experience as in other studies (Davis et al., 1987; Schröder & Davis, 2004; Orlinksky & Rønnestad, 2005). It is independent of level of experience and personality characteristics of the therapist, and could be considered as a differentiation of Schröder's (2004) situational difficulties. Our data showed a trauma-specific reaction pattern, including anxiety and shock and being overwhelmed by the client's material. These reactions resemble posttraumatic reactions, which lends partial support for the concept of secondary traumatic stress (Figley, 1995). However, it is premature to take this result as support for the idea that a client's traumatic experiences could traumatize therapists. In the expert-group, there were no differences in reaction patterns between trauma-experts and other psychotherapists. Intrusions seemed linked to the intensity of emotional involvement of the therapist rather than to traumatic situations. Avoidance was not leading to personal or professional impairment.

Holmqvist (2001) defined therapeutic style as therapists' typical reaction tendencies that colour their reactions to clients. Therapeutic style is dynamic, unless time shows otherwise and the therapist appears to be stuck in a certain position, entering

the domain of paradigmatic difficulties (Schröder & Davis, 2004). Our analysis of in-session reactions of a therapist across several difficult situations is comparable to Holmqvist's by anchoring 'therapeutic style' directly in the actual experience of the therapist. Holmqvist et al. (1996a; 1996b) described therapists' feelings along the dimensions Helpfulness and Closeness. Our study included feelings and behavioural responses. The dimensions Active and Responsible offer a framework for reflection on therapists' baseline reaction patterns and may facilitate a therapist's understanding of herself as therapeutic instrument (Kiesler, 2001).

Therapeutic style is time- and context dependent. It may be influenced by experience and conditions of the work environment. Moreover, Pearlman and Saakvitne (1995) proposed the 'countertransference-vicarious traumatization cycle' to describe how long-term trauma-specific cognitive distortions influence countertransference reactions. Although not directly addressed, these factors may account for some of the differences between our samples. Fewer trauma-institute therapists than experts report intrusions, shock and other trauma-related reactions. More of them tend to active reaction styles. Several interpretations are possible. Active coping could serve as defence against overwhelming trauma-related experiences. The relative absence of strong emotions in the trauma-institute group could also signal vicarious traumatization, or collective avoidance or shame, reflecting countertransference parallels in the organization (Pearlman & Saakvitne, 1995). Alternatively, trauma-institute therapists could be better able to recognize and cope with the trauma-stories and attend to other aspects of the client's problems that become more salient. The number of interactional and existential difficulties that trauma institute therapists mentioned may support the last option. Otherwise, the group differences on the dimension Active could indicate that the high level of professional experience of the experts helped them to bear strong feelings and cope with them in a reflective way (Normandin & Bouchard, 1993).

The comparison of the two samples of this study thus evokes several hypotheses about the influence of experience, work setting and trauma-specialization that need to be investigated in controlled and longitudinal designs.

Conclusions

First, therapists experience difficult situations throughout their professional career. Our results underscore the necessity of reflection on the different factors influencing the therapeutic process and adequate supportive actions. Depending on the identified origin of therapist reactions, these should focus on the personal contributions of therapist and client, and on contextual factors like experience and work setting.

Second, apart from lack of skills or the influence of personal issues of the therapist, different types of difficult situations were linked to specific reaction patterns. Understanding and acknowledgement thereof could refocus the therapist's attention to restoring the empathic relationship with the client.

Third, traumatic situations did evoke a specific and disturbing reaction pattern, but are not exclusive as high impact situations (signalled by intrusions) that need to be worked through.

Fourth, the framework of the two dimensions of therapeutic style and four reaction clusters may help clarifying therapists' baseline patterns in the therapeutic interaction. Further, it may support reflection on alternative positions that are thinkable or taken at times.

Training and supervision should lay the foundation for this attitude of ongoing personal development as essential part of the psychotherapeutic profession. It should include attention to long-term coping strategies like balancing activities and positive personal relationships that are an essential ingredient for successfully handling difficult therapeutic situations and continuing experience of the richness of the therapeutic profession.

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