

Researching Therapist Emotions and Countertransference

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The study of therapist emotions is discussed with emphasis on its centrality to clinical practice and its relationship to countertransference. The paper describes dilemmas in researching therapist emotions (e.g., whether therapists can and will report their emotions; what emotions are), examples of key findings from research studies (e.g., therapist emotions vary based on patient diagnoses; therapist emotions cluster into meaningful categories), and 8 suggestions to improve future research (e.g., relate therapist emotions to real-life clinical phenomena; do not assume an emotion is "positive" or "negative"). The study of therapist emotions is concluded to be a fruitful area of research that needs refinement in theory and methods to improve on more simplistic prior studies.

Your agoraphobic patient makes her first bus trip alone. *How do you feel?*

A patient tells you that "This treatment is going nowhere. I need to work with someone else." *How do you feel?*

You are asked to consult on a case and the patient looks exactly like your beloved deceased father. *How do you feel?*

Your patient inherits a fortune while you are struggling economically. *How do you feel?*

TERAPISTS experience an amalgam of feelings hundreds of times a day; it is a chaotic, complex, diverse universe of emotions that is inherently part of the work and also simply part of being human. The intensity of emotion in psychotherapy is what draws many therapists to the field. The dual-edged nature of emotion as both harmful to treatment (when too intense) and helpful to treatment (when used as a guide to the patient's internal world) is well-known (Epstein & Feiner, 1979). Therapist emotion is at times viewed as synonymous with countertransference or, at very least, as one of the main inroads to understanding countertransference (Holmqvist & Armelius, 1996a; Latts & Gelso, 1995).

Enter research, and the first question is often, "Fascinating . . . but can it be done?" Indeed, Singer and Luborsky (1977) have observed that the more one attempts to operationalize therapist countertransference emotions for research, the more likely one is to lose the complexity of the phenomenon. It is striking that only a handful of empirical studies has been devoted to therapist emo-

tions—despite over 40 years of psychotherapy research and the centrality of therapist emotions in clinical practice and many theories of treatment. The topic of therapist emotions exemplifies the classic split between psychotherapy practice and research: For most of this century, therapist emotional responses have been emphasized as crucial (particularly in psychoanalytic and psychodynamic models), yet we know very little about it. Within cognitive-behavioral therapy, emotions are also emphasized in clinical practice (Beck, 1979), despite a popular perception of behaviorists deemphasizing emotion in favor of thoughts and behaviors.

The past several years has seen a growing interest in the study of therapist emotions. In part, this interest stems from a broader attention to studying therapists in general. In earlier decades the "uniformity myth of therapists" (Kiesler, 1966) held sway in research—therapists were viewed as alike and research focused on patient variables and theoretical models of treatment. More recently, attention to how therapists differ in their outcomes has become more prominent: comparing "supershrinks" versus "subshrinks" or, in the language of managed care, "provider profiling" (Crits-Christoph, 1991; Crits-Christoph & Mintz, 1991; Luborsky et al., 1986; Luborsky, McLellan, Woody, & O'Brien, 1985; Najavits & Strupp, 1994; Ricks, 1974). As it became clear that therapists do indeed vary, and that therapists appear to account more for outcome variance than do theoretical models or patient variables (Luborsky et al., 1986; Luborsky et al., 1985; McLellan, Woody, Luborsky, & Goehl, 1988; Najavits & Strupp; Najavits & Weiss, 1994), a burgeoning interest in understanding therapists has arisen. Moreover, surprising findings that defy clinical lore (e.g., that increased experience is *not* associated with increased performance; Faust & Zlotnick, 1995) have led to a search for more complex variables by which to understand therapists. The older model of simple variables that could be easily measured (e.g., type of training, years experience, or sociodemographics; Najavits & Strupp, 1994) has been refined by

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Continuing Education Quiz located on p. 374.

increasing attention to more complex therapist attributes such as attitudes, cognitions, physiological responses, and, not least, therapist emotions.

Issues and Dilemmas

Can Therapists Report Their Emotions?

Even if therapists are entirely motivated to be honest, isn't the nature of countertransference—by definition—at least partly unconscious? And isn't it the case that the more the therapist is driven by intense emotions, the more likely it is that the therapist will be unconscious of them? (Brody & Farber, 1996; Imhof, 1991; Imhof, Hirsch, & Terenzi, 1983). Reporting one's emotions might, in fact, be viewed as an important therapist skill to be developed.

Will Therapists Report Their Emotions?

Even if therapists *can* report their feelings, *will* they? What conditions of research are needed for therapists not to fear repercussions of supervisors, embarrassment of being shown to be different from some norm, or just the very common fear of being judged by others for vulnerable emotions that may not fit the stereotypical image of the professional therapist? Will therapists report such feelings as jealousy, hatred, indifference, sexual attraction, inadequacy, confusion, or other "negative" emotions (Najavits, 1997; Singer & Luborsky, 1977)?

What Are Emotions?

Can emotions truly be separated from thoughts, behaviors, or attitudes (Ajzen & Fishbein, 1980)? Is "empathy," for example, an emotion? Or is it a mix of emotion ("I feel for this patient"), cognition ("I think the patient is suffering terribly"), attitude ("I really want to help"), and behavior (verbalizing an empathic statement to the patient)? Moreover, is emotion the same as countertransference, or, if not, how does it differ?

What Methods Should Be Used?

What procedures are needed to study therapist emotions in a valid way?—pencil-and-paper self-report of emotions (Colson et al., 1985; Colson et al., 1986; Holmqvist & Fogelstam, 1996), beliefs about emotions (Latts & Gelso, 1995), observation of verbal expressions on therapy audiotapes (Milmoie, Rosenthal, Blane, Chafetz, & Wolf, 1967), or of facial expressions on videotapes (Merten, Anstadt, Ullrich, Krause, & Buchheim, 1996), physiological measures such as galvanic skin response or biofeedback (Cassel, 1994), "think-aloud" tasks (Latts & Gelso, 1995)? Moreover, studies may vary considerably in

their ecological validity, ranging from a general personality test that includes a "feeling" subscale (Nelson & Stake, 1994), written responses to written vignettes (Brody & Farber, 1996), verbal responses to videotaped vignettes (Latts & Gelso), or ratings of the therapists' own cases (Holmqvist & Fogelstam; Najavits et al., 1995). Patients' ratings of therapist emotions could also be studied.

Do Therapist Emotions Vary Based on the Patient?

To what extent are therapist emotions an attribute of the therapist versus a response to a particular patient (Holmqvist & Armelius, 1996b)? For example, it has been observed that the more intense the patient's emotions, the more intense the therapist's emotions (Imhof, 1991; Imhof et al., 1983). Is the therapist experiencing her or his own emotions or expressing the patient's emotions that are "transferred" to the therapist via mechanisms such as projective identification? As one likely cannot have the same patient see 100 different therapists (holding the patient variable constant), each new dyad is a new research subject of sorts.

Is It Logistically Difficult to Study Therapists?

Even if all of the above issues can be resolved, studying therapists—particularly if one seeks to relate therapist variables to outcomes—is typically labor-intensive, time-consuming, and expensive. Many therapists do not want to be studied, and one might suspect that the weaker the therapist in terms of performance, the less willing he or she will be as a subject "under the microscope" of therapy research, thus narrowing the available range. Conducting rigorous outcome trials is usually a collaborative effort requiring external funding. Gathering a large enough sample of therapists to allow subgrouping (e.g., male versus female), randomizing patients to therapists in addition to treatments (Crits-Christoph & Mintz, 1991), and attaining a sufficient amount of patients seen by each therapist to achieve statistical power are rarely done.

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Examples of Studies on Therapist Emotions

Despite the dilemmas involved in studying therapist emotions, several creative and interesting studies have emerged that help to illustrate both the fruits of such research and also its dilemmas. The studies are organized below in terms of key findings.

Therapist Emotions Vary Based on Patient Diagnosis

Colson and colleagues (Colson et al., 1985; Colson et al., 1986) asked 44 professional staff of the Menninger Hospital to rate their emotional responses to all 127 inpatients under their care using a checklist of feelings. Emotional responses were found to vary based on patients' diagnostic categories: anger toward patients with primary character pathology, protectiveness toward patients with suicidal depression, and hopelessness toward patients with psychotic withdrawal. They also found that more difficult patients evoked a greater variety of emotions in therapists. Brody and Farber (1996) asked 336 therapists to fill out a rating scale after reading written vignettes and found that borderline patients evoked the most anger

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and the least liking, empathy, and nurturance; schizophrenic patients evoked the strongest wish to refer the patient elsewhere; and depressed patients evoked the most positive feelings. In contrast to these studies, however, Holmqvist and Armelius (1996a) found that the personality organization and level of pathology of the patient did not contribute much to therapists' emotional reactions in their study of 244 therapists using a feelings checklist in response to group home patients. In sum, two research projects, those by Colson (Colson et al., 1985; Colson et al., 1986) and Brody and Farber (1996), have found specific relationships between patient diagnosis and particular therapist emotions, while one study did not (Holmqvist & Armelius). If future research indeed confirms that particular patient diagnoses evoke predictable and consistent emotional responses in clinicians (e.g., borderline personality disordered patients evoking anger), this might be potentially valuable for therapist training and supervision.

Therapist Emotions Cluster Into Meaningful Categories

Given the seemingly endless number of possible emotions that could be studied, attempts have been made to cluster individual emotions into meaningful categories. Najavits et al. (1995) asked 52 therapists treating cocaine-dependent outpatients to complete a 40-item self-report rating scale of emotions; they found four factors in a factor analysis: "therapist in conflict with self" (e.g., confused, doubting one's competence), "therapist focused on own needs" (e.g., insufficiently paid, bored), "positive connection" (e.g., enjoyment, liking, empathy), and "therapist in conflict with the patient" (e.g., power struggles, feeling manipulated by the patient). Holmqvist and

Armelius (Holmqvist & Armelius, 1996a) conducted a factor analysis of 30 emotion words, finding two dimensions: helpfulness versus unhelpfulness and closeness versus distance.

Therapist Emotions Are Related to Treatment Phenomena

Several studies have been conducted on therapists conducting real treatment (rather than hypothetical vignettes or other laboratory experiments) and have found relationships between therapist emotions and treatment phenomena. An intriguing study by Milmoe et al. (1967) found, based on audiotape ratings, that the more anger and anxiety in doctors' voices during an initial interview, the fewer number of patients followed through on alcoholism treatment. In the Najavits et al. (1995) study described above, therapists' self-reported emotions became significantly more negative over the course of 24 sessions of treatment. Also, therapist emotions were found related to therapists' ratings of the helping alliance but not to patients' ratings of alliance. In a study using the Myers-Briggs Type Inventory on 35 experienced therapists treating outpatients, Nelson and Stake (1994) found that higher therapist feeling scores were associated with more positive ratings of the therapeutic relationship by both patients and therapists.

Therapist Emotions Are Related to Other Therapist Characteristics

Studies have found relationships between various therapist characteristics and therapist emotions. For example, Colson et al. (1986) studied emotions in relation to clinical training and found that psychiatrists and social workers were more similar to each other in affective responses than they were to nurses and activity therapists. Brody and Farber (1996) studied experience level and found that novices, compared to experienced therapists, were significantly less comfortable with their emotions in treatment. Najavits et al. (1995) studied theoretical orientation and found that 12-step counselors reported more positive emotions toward cocaine-dependent patients than did cognitive or supportive-expressive therapists. In terms of therapist gender, Pope and Tabachnick (1993) found that male therapists reported more sexual attraction to patients than did female therapists; Latts and Gelso (1995) found that male therapists had more "avoidance" feelings than female therapists in an investigation of treatment of date rape.

Studies have found relationships between therapist emotions and their professional training (Colson et al., 1985; Colson et al., 1986), experience level (Brody & Farber, 1996), theoretical orientation (Najavits et al., 1995), and nationality (Cheng & Page, 1995). Two studies

evaluated therapist "countertransference" (rather than emotion per se) in relation to therapist gender, with one finding a significant relationship (Lecours, Bouchard, & Normandin, 1995) and the other not (Latts & Gelso, 1995).

Therapist Emotions Are Context-Dependent

Several studies have evaluated whether therapist emotions reside within the therapist or, in contrast, are dependent on the treatment context. Holmqvist and colleagues, in the study described above, found that therapist emotions were related to the atmosphere of the psychiatric milieu (Holmqvist & Fogelstam, 1996); they also found that approximately 15% of therapists' emotional reactions were consistent within the therapist rather than varying by patient (Holmqvist & Armelius, 1996a). Siol and Stark (1995) studied 12 therapists treating 21 schizophrenic patients using measures of expressed emotion and found that a high level of emotionality in therapists was more associated with particular patients than with the therapist per se. Finally, in another report on Holmqvist's study (Holmqvist & Armelius, 1996b), three sources of therapists' emotions were evaluated and all three were found to be significant contributors to the total level of therapists' feelings: the therapist, the patient, and the particular therapist-patient dyad.

Suggestions for Research on Therapist Emotions

While research thus far appears fruitful, it is nonetheless in an early stage of development. Based on the literature and my own experiences studying therapist emotions, several suggestions can be made to facilitate work in this area. The REACT measure (Ratings of Emotional Attitudes Toward Clients by Treaters; Najavits & Colson, 1992; Najavits et al., 1995) will be used as an example, in part because of my direct experiences with it and also because it appears to be the only measure of therapist emotions thus far that has been used in a controlled psychotherapy outcome trial, related to therapeutic alliance and therapist theoretical orientation, developed in relation to a homogeneous and rigorously diagnosed patient sample (cocaine-dependent outpatients), and repeated over the full course of treatment.

1. Seek to Relate Therapist Emotions to Real-Life Clinical Phenomena

Examples of important clinical phenomena include retention in treatment, helping alliance, patient outcomes using standardized measures, patient diagnosis or severity, therapist burnout, or any other clinical domain that already has a developed, rigorous assessment

method and has real-world implications. Without such "hard" data, it can be extremely difficult to understand how to interpret findings on therapist emotions. For example, in my study on the REACT measure (Najavits et al., 1995), it was found that psychodynamic therapists reported more negative feelings than 12-step drug counselors. (Negative feelings on the scale were items such as "frustrated," "confused," "angry," and "disappointed.") Are more negative feelings a sign of greater awareness of the complexity of one's internal world or, rather, a sign of a therapist in distress who may be harming a patient? Without being able to correlate the negative feelings with a known clinical phenomenon, no interpretation can yet be made.

2. Use Terms Clearly

While this may seem like a caveat for all research, it is particularly so in the realm of therapist emotions, where terms such as "countertransference" or "attitudes" are sometimes considered synonymous with "emotions." Countertransference is a particularly thorny area: Most definitions, at least in part, refer to the unconscious, which may be very difficult to study, particularly using therapist self-report. If a therapist reports what she or he is aware of feeling, it will be most parsimonious to restrict the discussion to feelings and not to assume that countertransference is involved without a more sophisticated paradigm. This also means that when conducting a literature search, be sure to search for a multitude of terms (e.g., *feeling, emotion, mood, attitude, countertransference, affect*) as there currently appears to be no consensus on how these terms are used. For example, the term "attitude" is usually taken to mean an "opinion" or "cognition," but esteemed social psychology researchers Ajzen and Fishbein label an attitude a positive or negative "feeling" (Ajzen & Fishbein, 1980). A study by Latts and Gelso (1995) illustrates the difficulties in labeling: They used a 5-item scale called Awareness of *Feelings* (emphasis added), which actually appears to be a measure of *beliefs* (i.e., therapists rate their general views on "countertransference," such as "How useful do you find countertransference feelings?"), which results in a total score labeled *countertransference*. Moreover, this "countertransference" measure was completed by therapists without specification of any stimulus, such as a particular patient, and

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without a specified time frame. Though an intriguing study with some interesting findings, it exemplifies the difficulties inherent in current terminology. Few studies of countertransference or emotions thus far have used the same measures or assumptions (e.g., Holmqvist's and Armelius, 1996a, 1996b, use the term "countertransference" for a yes/no checklist of 30 emotion words in contrast to the Latts and Gelso method above).

3. Do Not Assume an Emotion Is "Positive" or "Negative"

It is tempting for scoring purposes to define emotion items as positive or negative (e.g., "enjoyment" is positive and "anger" is negative). But upon reflection it becomes clear that the researcher cannot make such leaps without

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further exploration. For example, does the therapist view the emotion as positive or negative? An emotion such as "sadness" may be appropriate in relation to hearing a patient's very moving life story, which the therapist may not view as negative (much as going to a sad movie is not a negative experience for many people). Moreover, an emotion is positive or negative in relation to some real-world outcome, but in a therapeutic environment, a therapist's anger may be a clue into the patient's pathology and thus

facilitate a more insightful therapy that would be missed by a therapist who guards against feeling angry. The degree of intensity of emotion, the stability of emotion, and the awareness of emotion also are not yet understood well enough to know what can be labeled "positive" or "negative" about them. It may be assumed, for example, that a therapist who is more aware of emotions is a better therapist, but this has not yet been evaluated. There may be many types of excellent therapists—some are more emotion-focused and some are more intellect-focused (Najavits, 1997).

4. Take Exceptional Care to Guard Therapists' Confidentiality

Confidentiality is necessary in all research, but may be particularly crucial in a study of therapist emotions in which therapists are asked to reveal some of the most vulnerable, personal experiences in their professional work. They are rightly often concerned about others' access to their measures (e.g., supervisors? support staff involved

in data entry? insurance companies?), even when there are no immediate consequences, such as job loss, for "wrong" answers. One method that can be very helpful to ensure total confidentiality is as follows: (a) Ask each therapist to pick a number from 1 to 1,000 that he or she alone will know; (b) ask therapists to fill out all measures using this secret number and drop measures into a common bin (or mail in an anonymous interoffice envelope); (c) if relating patient data to therapist data, ask therapists to similarly assign unique numbers to their patients and have therapists write the patient numbers on the patient forms and give patients the necessary measures, then returning those measures in the same way (e.g., anonymously through interoffice mail). Using this method, no one, including research staff, the principal investigator of the study, or other clinicians, can identify which therapists completed which forms. Even if the researcher needs to directly interview patients on such a study, she or he would not need to necessarily know which therapist the patient is seeing. In short, be aware that therapists are often more concerned about confidentiality than patients in research studies and may not be used to the role of "subject" in a study; implementing extremely rigorous confidentiality constraints may be essential to obtain valid data.

5. Solicit Therapists' Knowledge

The well-known gap between research and clinical work is sometimes the function of different cultures assuming others cannot really understand their world. When researchers are studying therapists, they sometimes assume that therapists should simply fill out measures without involving therapists in more in-depth, qualitative discussion of the research hypotheses and findings. Yet therapists are likely the most important source of knowledge on the topic of therapist emotions, and truly attempting to explore their views may help in designing the study, setting hypotheses, interpreting data, and creating scales. At each stage, piloting the research combined with open-minded discussions may change the course of the work.

6. Don't Assume that Therapists Do Not Want to Be Studied

Historically, the imbalance of most psychotherapy outcome studies—huge numbers of patient measures but few, if any, therapist measures—may stem from a prevalent assumption that therapists either do not want to be studied or will not comply with research demands. In conducting my studies, I find therapists to be largely appreciative of research that attends to their experiences, as long as it is done with respect, a minimal burden (e.g., brief measures or compensation for their time), and a se-

rious motivation to genuinely understand their part of the therapy equation. The REACT measure that I used was initially critiqued as "too intrusive—therapists may not want to fill it out." Yet, in conducting the study, I never received a single complaint about the measure. The response rate on the scale was high and several therapists specifically said that they enjoyed filling it out as it made them think more about their feelings toward patients.

7. Include a "Can't Say" Item in Therapist Measures

As reporting emotions requires awareness and also a willingness to be honest, it is necessary to allow for the possibility that a therapist either may not be aware of particular emotions or may not want to report them. By including a "can't say" option on each item, the therapist is allowed to opt out of an item that she or he cannot or does not want to rate. In my REACT study, only .0001% of the responses were "can't say," and these were found not to vary over time or by theoretical orientation of the therapist. This helped confirm that the items made sense to therapists without assuming this a priori.

8. Develop Theories and Methods

The current early stage of research on therapist emotions requires advances in both theory of emotions and methods of assessing them. Drawing from lab-based psychological and biological research on emotion or well-studied paradigms of emotion in clinical studies [e.g., the expressed emotion model used in schizophrenia research (Sjol & Stark, 1995; Stark & Sjol, 1994)] may be helpful, as is drawing on descriptive, nonempirical clinical writings. For example, in developing the REACT, I conducted an extensive literature search on "countertransference/emotion, therapists, and substance abuse" and found that numerous clinical writings emphasized specific therapist emotions that were believed important in treating substance abuse patients (e.g., optimism, a low need for control); I then modified, with permission, a scale by Colson (Colson et al., 1985; Colson et al., 1986) used to study therapist emotions toward general psychiatry patients. Until this area of research is more developed, conducting psychometric tests of measures is essential and using multiple measures is recommended (Scherer, 1995). One new avenue attempts to develop an affective dictionary for the purpose of studying therapist emotions (Hoelzer, Scheytt, Mergenthaler, & Kaechele, 1994) based on a structural theory of emotions. Methods for studying therapist emotions can include questionnaires, "say-aloud" tasks, Q-sort methods, journals, observation, biological measures, hypothetical vignettes, interviews, and identifying critical incidents that evoke emotions (see Najavits, 1997).

Implications

If the study of therapist emotions continues to grow, it has the potential to help address a number of current issues in psychotherapy, including topics such as identifying effective versus less effective therapists, how manualized treatments are differentially implemented, ability to learn and respond to training, burnout, selection of therapists for jobs, and other realities of current clinical practice.

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