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Therapists' in-session experiences with depressive clients: A grounded theory

JAN ROUBAL & TOMAS RIHACEK

Department of Psychology, Masaryk University, Brno, Czech Republic

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Abstract
Objective: This study explores the experiential process of psychotherapists during a session with a currently depressive client. **Method:** Individual and focus group interviews were conducted with 30 therapists and the grounded theory method was used as a methodological framework. **Results:** The therapists' experience was conceptualized as Experiential oscillation between getting closer to a client's depressive experience and moving away from it. Its development over the course of a session is depicted by a six-phase Depression Co-experiencing Trajectory model. **Conclusions:** The resultant theory interconnects different therapists' emotional responses to a depressive client within a coherent process model, which allows us to track the changes in therapists' experiences, to name the relations between them, and to connect them with the therapy's in-session microprocesses.

Keywords: depression; therapists'experience; therapeutic relationship; countertransference; grounded theory method

A large amount of clinical and empirical literature describes how psychotherapy can help a depressed person, but comparatively very little is known about the experience of the helper who comes so close to the depths of a client's depression and strives to aid the depleted client in resolving it. A shared clinical observation warns that working with a depressive client can cause therapists' own moods to deteriorate, and they have to be cautious not to fall too deep into it (Rahn & Mahnkopf, 1999). Therapists exposed to their clients' powerful depressive emotional states are generally poorly prepared for it. They are trained in therapeutic openness and an empathic stance, but seldom in protecting themselves specifically from vicarious depressive experiencing. To help prepare them, we need to know more about the experience of therapists who encounter depressed clients. What are their feelings, thoughts, body awareness, needs, and support systems?

Although depressive clients are on one side "easy to love," dealing with such clients can conversely give rise to feelings of inadequacy within their therapists (McWilliams, 2011). Self-doubts or overprotective tendencies toward clients who, due to their depression, are unable to respond can burden therapists and destroy their enthusiasm for their work and well-being in a relatively gradual and imperceptible way. Wolf, Goldfried, and Muran (2013a) describe this creeping load, saying that when therapists

> look at their clock every 5 minutes hoping for the end of the hour while sitting with a self-absorbed client who barely recognizes the therapist's presence, they may become self-critical, feeling inadequate and regretting joining a profession that forces them to subordinate their own needs to those of another. (p. 5)

Indeed, as Koekkoek, van Meijel, and Hutschemaekers (2006) found in their extensive literature review, patients with chronic depression are considered by clinicians as one of the main types of "difficult patients" for their demanding, self-destructive, and

Correspondence concerning this article should be addressed to Jan Roubal, Department of Psychology, Masaryk University, Jostova 10, Brno 602 00, Czech Republic. Email: jan.roubal.cz@gmail.com

dependent behaviors. It is depressed clients' helplessness and hopelessness that can activate strong negative reactions in their therapists (Wolf et al. 2013a, 2013b). Therapists can then become ensnared by their own negative emotions and perceive themselves as helpless, which can subsequently create doubts about professional suitability in beginning therapists, and cynicism and despair about effectiveness in experienced professionals (Wolf et al., 2013a, 2013b).

Working with depressed clients can not only erode therapists' professional self-confidence but also endanger them personally. Research studies show that dispirited and depressive clients have a significant stressful impact on therapists (Deutsch, 1984). In her qualitative study of countertransference experiences of psychotherapists who have personal histories of psychiatric hospitalization, Cain (2000) revealed that these "wounded healers" experienced varying degrees of identification with clients. Similarly, in the study by Brody and Farber (1996), depressive clients were rated as evoking the greatest degree of depression in their therapists. The specific nature of such depressogenic influences is described by Coyne (1976a) in his theory about the interpersonal aspects of depression and its contagiousness, which was also supported by Joiner's (1994) empirical study.

Therapists can therefore be seen as risk workers, as they are endangered by their own depression, which is one of the most common expressions of psychotherapists' professional crises (Gilroy, Carroll, & Murra, 2002). Although negative experiences with difficult clients are a risk factor for professional distress and burnout syndrome (Jenaro, Flores, & Arias, 2007), therapists are, in general, at risk of marginalizing their experiences with clients as idiosyncratic and subjective, or even devaluing them as intrusive, counterproductive, and unprofessional (Wolf et al., 2013a, 2013b). By perceiving their own reactions as mere "noise" in the therapeutic process, therapists not only elevate the risk of developing burnout syndrome but also "risk missing an important source of data that may directly or indirectly affect the therapeutic alliance and negatively influence treatment outcomes" (Wolf et al., 2013a, 2013b, p. xiii). Ignoring one's own experiential responses to clients can even lead to harming clients (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010).

Existing research remains limited to mainly cataloging therapists' experiences with depressive clients and sometimes comparing these experiences with therapists' reactions to clients with different diagnoses, for example, borderline or schizophrenic (Boswell & Murray, 1981; Brody & Farber, 1996; McIntyre & Schwartz, 1998). There is also a lack of studies that distinguish long-term impact from immediate in-session influence. A few studies have been conducted on therapists' experiences during therapy sessions in general (e.g., Deutsch, 1984; Howard, Orlinsky, & Hill, 1969; Williams, Polster, Grizzard, Rockenbaugh, & Judge, 2003), but these did not deal with the psychotherapy of depression.

Given the need to address therapists' experiential reaction, alongside the lack of specific empirical literature in this field, we formulated our research question as follows: "How do therapists experience a psychotherapy session with a currently depressive client?" From the original interest in therapists' experiences with depressive clients in general, the focus of the study was further specified to include only in-session microprocesses (in contrast to long-term impact). Within this specification, we focused on all reactions evoked in the therapists and did not attempt to distinguish countertransferential and non-countertransferential components of therapist's subjective experience described by Gelso and Hayes (2007).

Given the exploratory nature of the research question, qualitative methodology was deemed appropriate. Although the experiential focus of the study might suggest phenomenological analysis (e.g., Smith, Flowers, & Larkin, 2009) as a suitable approach, grounded theory method has been chosen for its capacity to capture the processual aspect of a phenomenon. The Straussian version of the method (Strauss & Corbin, 1990) has been adopted in this study, as it specifically emphasizes this processual aspect.

Methods

Participants

Therapists. Thirty Czech therapists (17 females and 13 males) participated in this study. Their ages varied between 26 and 67 years (m = 40.1, SD = 10.3), and they had between half a year and 37 years of experience working with depressive clients (m = 10.3, SD = 8.9). The sample represented a variety of theoretical orientations: psychodynamic/psychoanalytic (16), humanistic/experiential (15), systemic/family systems (3), cognitive-behavioral (2), and integrative (2). Twenty-three of the therapists were trained in one approach, 6 in two approaches, and 1 in three approaches. The uneven spread of theoretical orientations followed from the research process. According to the principle of purposeful sampling (Patton, 2002), we made theoretically informed choices of research participants at different stages in the research process. At the first stage, this

involved identifying relational-centered therapists and conducting individual interviews with eight of them in order to explore the topic in depth and develop the basic model. At the second stage, we selected 22 therapists with a range of theoretical orientations and conducted two focus groups with them in order to elaborate the theoretical model and assess the relevance and transferability of the model to therapists with different backgrounds. Finally, we tested the model via a targeted interview with a therapist whose theoretical orientation was absent from the sample (Cognitive Behavioral Therapy [CBT]). All participants signed an informed consent form. To protect their identity, fictional names are used in this study.

Analysts. The authors are therapists with 18 (the first author) and 9 years (the second author) of practice. They both have experiential orientation in common, in this case gestalt therapy. The first author, who has extensive therapeutic experience in working with depressive clients both in the context of a psychiatric hospital and in private practice, collected all the data and served as the main analyst in this study. The second author, who encounters clients with depression less frequently, served as a co-author of the research design and an auditor analyst.

Following from their theoretical orientation, the authors were influenced by gestalt therapy's interpersonal perspective on depression. This perspective served as a sensitizing concept (Charmaz, 2006) in this study, which was explicitly acknowledged and therefore provided us with a general framework for understanding the phenomena under study. In gestalt therapy, depressive symptoms are seen as an individual expression of a specific relational experience. Depression is understood as a fixed relational phenomenon, which is co-constructed in a stereotypical ongoing way by both the depressive person and the others. It is characterized by (i) a profound attachment, whereby the other is loved and necessary, (ii) the failure of all efforts to reach the other, and (iii) the emotive absence of the other from the relationship (Francesetti & Roubal, 2013). In the here-and-now therapeutic situation, the client and the therapist are in a way "depressing together," (Roubal, 2007) as they both co-create the interpersonal vicious circle of depression, in which the lack of energy prevents them from establishing satisfactory, mutually energizing contact.

Procedure

In line with grounded theory method principles (e.g., Charmaz, 2006; Strauss & Corbin, 1990), data creation and analysis were intertwined throughout the research process. Therefore, we decided to structure this section according to the phases that naturally emerged during the process, rather than split it into the standard subsections of recruitment, data creation, and analysis. The analysis has been partially conducted using the Atlas.ti software (version 5).

Phase 1: Researcher's self-reflection. Finlay and Evans (2009) emphasize the importance of reflecting on the researcher's emotional and relational aspects, which enter unconsciously into the research process. Using the two-chair technique, as suggested by Finlay and Evans, the first author interviewed himself about his own experience of conducting therapy with depressive clients, as well as his preconceptions about the topic and his own attitude toward the phenomenon of depression. The interview was transcribed and later submitted to the auditor (the second author), together with the results of the analysis (see Phase 6).

Phase 2: Conducting individual interviews and formulating a provisional central concept. The first author conducted semi-structured individual interviews with seven therapists. To be included in the sample, the therapists had to meet three criteria: (i) completion of a psychotherapeutic training, (ii) a minimum of 5 years of therapeutic practice, and (iii) experience working with depressive clients.

The interviews began with the prompt: "Try and recall a session in which one of your clients is going through depression," followed by the question: "What did you experience in that moment?" The participants' experience was then explored in a more detailed way with questions such as: "Did your experience change somehow over the course of a session?", "What did you do?", "What did you find helpful?", "What happened next?", and "What did you experience then?" and also using metaphors. The first author analyzed verbatim transcripts using open coding procedures (Strauss & Corbin, 1990) before the next interview took place, which allowed subsequent interviews to become more focused. At the end of this phase, the central concept of finding "an experiential distance from the client" emerged from the analysis.

Phase 3: Conducting focus groups and developing categories. The first author conducted two focus groups, consisting of 14 and 8 therapists consecutively, which were aimed at further developing and refining the categories from the previous analysis. The focus groups took place at a national psychotherapeutic conference. The participants were

recruited through an invitation leaflet and had to have (i) their therapeutic training completed and (ii) experience in working with depressed clients in order to qualify for the study. These therapists are referred to by their group number (FG1 and FG2) in the following text. During this phase, the central concept was elaborated into "oscillation" between therapists' attunement to their clients' emotional experience and therapists' withdrawal from that experience.

Phase 4: Developing a modified axial coding paradigm and reanalyzing the data. To develop theoretical relationships among concepts, two methodological steps were taken: (i) recollections of 32 particular therapeutic events were extracted from the data (leaving out generalized statements made by therapists about the topic and, in some cases, gathering information about an event scattered throughout an interview) and (ii) a modified axial coding paradigm was developed and used to reanalyze this set of events.

For the development of theoretical relationships among concepts, Strauss and Corbin (1990) prescribe their axial coding paradigm. While we find this analytical approach helpful in a generic way, in our case, we had to modify the paradigm to fit the research question and the nature of our data. Based on the previous analysis (Phases 2–4), we set up the following paradigm: Situation → Experience → Coping → Consequence. We then used this paradigm to reanalyze the data in a more detailed way, with an event serving as the analytical unit. Thus, within each event description, we endeavored to find relationships among the contextual characteristics of the particular therapeutic situation, therapists' experience, their ways of coping, and consequences. Six event descriptions were deemed incomplete regarding the axial coding paradigm (i.e., substantial information on some of the components of the paradigm was missing) and were therefore removed from the following analysis. Another four events had to be removed because closer examination revealed that the clients' were not actually depressive, though their problems resembled depression. This reduction resulted in a set of 22 analyzed events.

Phase 5: Formulating a sequence model and searching for variability in the process. Using the constant comparative method (Charmaz, 2006; Glaser & Strauss, 1967), the event analyses from the previous step were compared to each other to look for similarities and variability across the set of events. Based on this step, a theoretical model was created. It described a general sequence of phases, which evolved from the process of therapists' dealing with their emotional reactions to contact with their depressive clients. This sequence was then validated by reanalyzing the individual events again and searching for irregularities or contradictions in relation to the model. This thorough analysis led to further consolidation of the model and the description of three different variants of the phase sequence, as described in the Results.

Phase 6: Validation of the model through theoretical sampling. The authors were aware that their model is based on a sample of therapists with predominantly psychodynamic/psychoanalytic or humanistic/experiential orientations. Therefore, following the principle of theoretical sampling (e.g., Strauss & Corbin, 1990), the first author conducted an interview with an experienced CBT-oriented therapist (24 years' experience of working with depressive clients). This interview contributed two more events to the data set. These additional events were analyzed using the procedures described in Phases 4 and 5, and the results were found to be fully consistent with the model. As another form of validation, the first author presented the sequence model to the CBT therapist at the end of the research interview and he stated that the model corresponded very well to his own experience. Given the fact that even data from such a different source did not provide any new information, the authors concluded that theoretical saturation had been reached at that point.

Phase 7: Validation of the model by an auditor analyst. As the final step, the second author performed an audit of the analysis by comparing the original events' description with the resultant model. The auditor concluded that: (i) the theory was well-grounded in data and did not omit any important aspect present in the data and was theoretically consistent, (ii) the preconceptions and initial assumptions of the main researcher (as reflected in the interview conducted in Phase 1) did not distort the analysis process in any undesirable way, but instead increased his theoretical sensitivity (Glaser, 1978; Strauss & Corbin, 1990) toward phenomena present in the data. The auditor also provided comments that helped to further consolidate the final model.

Credibility Checks

Several steps were taken to ensure the credibility of the study: (i) the researcher's self-reflection in respect to the topic under study, (ii) repeated analysis of the data, which revealed more subtle meanings and allowed for more structured and detailed elaboration of the model, (iii) employing

theoretical sampling and following the principle of theoretical saturation, (iv) employing an auditor analyst, (v) utilizing feedback from focus group participants who compared the final model to their clinical experience.

Results

Experiential Oscillation

The therapists tended to describe their own in-session experiences in relation to their client's depressive experience as either similar or contrasting. They used the metaphor of "experiential distance" and described how they were experientially "getting closer" to a client's depressive experience and "moving away" from it. "Experiential oscillation" served us as an overarching concept describing the changes of the therapists' experiences: "During the therapy session I felt … as if I was going towards her [the client] for a while and then going aside.… I kind of oscillate in it" (FG1).

"Experiential oscillation" was described metaphorically as moving up and down in a well:

> A well, as the depth of depression and … the surface, as the light of day. I have a feeling I want to stay at the depth of the depression in order to be there with the client. And at the same time to maintain contact [with the surface above].… It pulls me in both directions.… I would either get angry with the client and leave him, or I would release my grip on the surface and be there with him and start to identify with him.… [The surface is] the daily reality, how I am normally, how I live in my world. (FG1)

Depression Co-experiencing Trajectory

The process of therapists' "Experiential oscillation" between the two poles gradually progressed over the course of the therapy session. We were able to identify distinct in-session phases in this progression and have depicted their typical sequence in the general Depression Co-experiencing Trajectory depicted in Figure 1. In some cases, this general sequence was repeated even more than once during one session, while in other cases, only parts of it could be recognized.

Phase 1: Sharing depressive experience. In this phase, therapists' experience became similar to the experience of their depressive clients. Therapists experienced self-doubt, feelings of failure, helplessness, hopelessness, and also overall dullness and tiredness. They reported experiencing symptoms of depression themselves as if they were falling into depression with their clients. They were losing distance from their client's experience, they were missing a broader perspective, and they felt that they were being pulled down into the depressive experience themselves: "It happens to me … that I fall into it somehow. Down. I am saying to myself: 'This is so terribly hopeless. It's no wonder at all that there is no way out'" (FG2). Therapists experienced sadness, anxiety, emptiness, fear for a client, and fear of their own failure. They perceived a loss of the ability to think clearly and to concentrate. On a bodily level, they felt stiffness, heaviness, weakness, and exhaustion: "When I am sitting with him there, I feel a terrible tiredness.… As if I will not be able to raise my hand anymore" (FG2). Therapists also felt overwhelmed by a feeling of hopelessness: "Nothing has any meaning and nothing works" (Fanny). Therapists shifted so close to their clients that they stopped perceiving themselves. Their experience was merging with the experience of their depressive clients.

Phase 2: Turning to oneself. After the previous phase, therapists started to perceive co-experiencing the client's depression as personally dangerous: "The client is pulling me down. It is killing me" (FG1). Therapists felt threatened by the situation: "Not to sink into it too much" (FG2). The intensity of the therapists' depressive experience increased until it reached a turning point, where therapists stopped resonating with their clients' experience. Instead, they changed their focus to themselves and instinctively started to protect themselves like Garry: "Protect myself!… [Do not] let myself feel this overwhelmingly negative attitude she has towards herself." One therapist described how the shared depressive experience changed his self-perception. He got so close to the depressive client "emotionally" that he stopped perceiving himself as an expert—a person tasked with and capable of helping. Only once his experience reached a certain intensity did he disconnect himself from his client and become aware of himself, his role, and resources:

> When I get closer to that client in my emotions, there is a kind of limit, when I say to myself: "It is so heavy!" [And in my mind to the client:] "Man, you should go see a psychologist". Then I realize that that's exactly what he's doing!… I actually forget I am a psychologist. Because I perceive how very heavy it is for me, while he is describing it to me. (FG2)

"Turning to oneself" became a moment of intensive self-awareness for the therapists: "I try to straighten up … to become aware of my breath, just breathe more.… Through my body to be in touch with who I am. Not to be flooded by it" (FG2). At this point, therapists' experience started

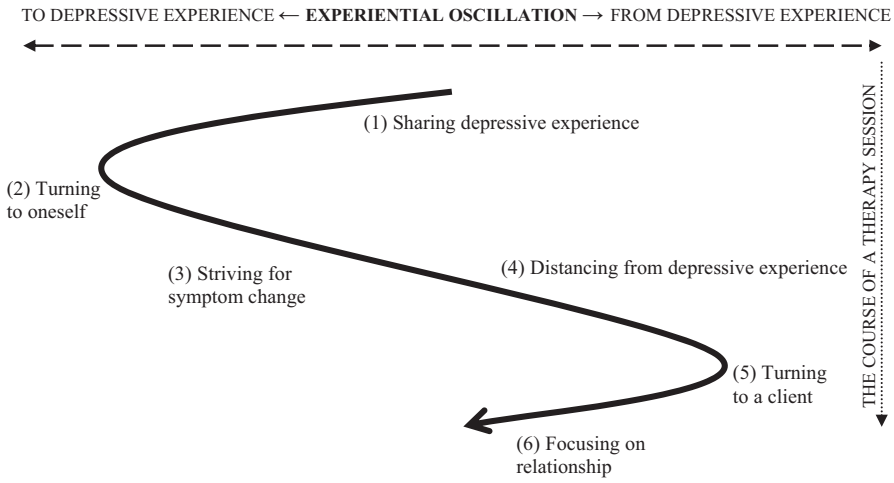

Figure 1. Depression Co-experiencing Trajectory.

to move away from the depressive experience of the client.

Phase 3: Striving for symptom change. After this turning point, therapists stopped co-experiencing depression with the client and took a safer, experientially more detached expert position. From this position they then focused on the symptoms of their client's depression, thus they were able to externalize and depersonalize the overall depressive experience. This prevented them from falling further into co-experiencing depression and provided them with a feeling of distance. They took a more directive therapeutic approach, gave practical advice to their clients, and tried to help them solve their problems: "It tempts me to look for a solution" (Diana).

Therapists strived for an effective treatment of depression and took responsibility for the change in the client. Interventions that were meant to change symptoms of depression served also as a way of escaping from being drawn into the previously mentioned feelings of helplessness:

> I get activated by that person. I start to be very active all at once, I start to invent, I start to have a lot of suggestions, and I start to take care of him.… I know it is almost a kind of trap that I can get caught up in. That it is easier for me than to stay with him [in the depression]. (FG2)

Therapists' experience became polarized against their clients' depressive experience: "A kind of mobilizing potential … starts coursing through me kind of automatically. The more gloomy the person is, the more fiercely I mobilize myself' (FG2). Therapists tried to supply their clients with optimism, to change their clients' attitude toward themselves and the surrounding world, to divert them from their current depressive experience and focus on pleasant and positive aspects of life, and to value their clients' qualities and potential. Later they realized these interventions served to mainly help them handle their own experience:

> I feel the heaviness … and I am trying to show … that actually just the fact that he came here is meaningful. That he is doing at least something. And many times I have realized that I am doing this more for myself in that moment. (FG2)

Phase 4: Distancing from depressive experience. As the therapy session proceeded, the experience of therapists distanced itself more and more from the depressive experience of their clients. Therapists' efforts to change the symptoms of their client's depression appeared fruitless within the session. Encouragement, activity, and an optimistic approach did not lead to any change, and therapists were not satisfied with the results of their efforts. The clients were not changing according to the therapists' expectations. They stayed depressive, immersed in their feelings of emptiness, resignation, and hopelessness. Therapists got the impression that they were "pushing somewhere where the path was closed" (Fanny), the therapy situation got stuck somewhere, and the client got "fossilized … in the same cycling topics and the same repeating sentences: that nothing has any meaning anyway and that she will never get rid of it [depression] and that the world is so joyless and…." (Joseph).

Therapists became impatient and frustrated. They implicitly started to blame their clients for their own failures and they felt angriness: "I simply feel a kind of angriness. I am really angry.… The immobility, the inertness [makes me angry]. [It is] as if you're trying to call into a black hole" (FG1). "I am angry at him, feeling that I would like to kick him [to make

him move]" (FG1). Therapists started to see their clients mainly as carriers of symptoms which do not want to change according to the therapists' expectations: "Kind of feeling like [saying to the client]: 'If only you would want a bit, try a bit more, it would be possible!' So, this is what it evokes in me" (FG2).

The therapists differentiated themselves from the experience of their clients: "I was saying to myself: 'My god, I must never become like this" (Cecile). The clients' experience seemed incomprehensible to them or they belittled it: "It seems unreal to me that something like this [state of mind] can exist. It is a totally unbelievable thing for me" (Brian). Therapists felt a tendency to avoid further contact with the client, and they considered sending the client to another expert or ending the therapy.

Phase 5: Turning to a client. Therapists got experientially so far from their clients that they lost empathy for them. They protected themselves so much from co-experiencing depression with the client that they temporarily left their helping position:

> It comes to my mind that it would probably be good if he commits the suicide that he has been talking about this whole time.… This thought enters my mind. And it stops me. This is exactly the kind of stop sign that turns me back again … [I feel] even a kind of horror and shame [at that moment]. (FG2)

Therapists were coming to a turning point where they admitted that their effort to relieve the client from symptoms of depression was not successful. They ended up exhausted and frustrated from trying to make their clients change, which was not possible at that moment. They stopped struggling and became reconciled to the actual limited possibilities of the client and the whole therapeutic situation. They accepted the given reality of their clients' actual state and started to change their therapeutic approach: "I realize … that my hastiness or rapidity or heaviness is pushing me to be fast, demanding.… So I [change it and] I just stay there … I am more silent again … adjusting myself to his speed" (FG2). Therapists left the role of the expert responsible for making the change and instead simply stayed in the presence of the other: "I can sit with her, but I cannot help her" (Cecile).

In this phase therapists experienced most intensively the inner tension between a natural tendency to protect themselves on one side and their professional responsibility on the other. "Turning to a client" became a moment of an awareness of the client's presence as a person whom the therapist is meeting.

Phase 6: Focusing on the relationship. After the second turning point, the therapists' experience started to come closer to the depressive experience of the client again. Instead of focusing on symptoms, therapists turned to the relationship now:

> I am joining her. Nothing gets better really, we will not come to any solution, will not come to anything [new], but a kind of contact can happen. I am with her, … [there is] some kind of a relationship. (Fanny)

This was not only a change in their therapeutic approach toward the client, but it also served as a way of coping with the therapists' own experience:

> Well, I have a feeling that it … that it helps me, when exactly these moments of some deeper contact happen. That I start to perceive it a bit meaningfully and somehow in this way I can like the person despite all that. It helps me that there is not only the darkness, but actually also something alive. Something really alive! [It helps me] that there is not only the "death", … [but also] life is there.… When I got closer to her, I did not feel only her depression, but also her as a being. (Fanny)

Therapists redefined their role in the current situation, and it helped them to start moving toward the client again: "I stop prompting him to move, and I join him instead" (Fanny). Resignation to changing the symptoms and focusing on the relationship instead made their work personally meaningful again. It brought them relief and helped them to stay with the client:

> It was a relief.… It really was a relief, when I had the feeling that it [the change of depressive symptoms] is not a kind of duty.… That [just] our meeting by itself … has some positive effect for her.… So this really helped me. (Joseph)

Therapists no longer took on all the responsibility for the therapy process as they did in the phase "Striving for symptom change," but they also did not place the responsibility solely on the client as in the phase "Distancing from depressive experience." They considered it shared by the therapist and the client, and this helped them handle their experience in the presence of their depressive client.

The therapists experienced ambivalence. They felt relief when abandoning the unproductive effort, but they remained in the unpleasant experience with the client at the same time:

> It was like grounding firmly. You sit down, stop floundering in a kind of activity, you just simply sit down. On the one hand it is a relief from activity, but on the other, you are still sitting in something nasty. (Fanny)

Variability of Depression Co-experiencing Trajectory

Therapists' experiences during every particular event can be described by a specific variant of the Depression Co-experiencing Trajectory using two aspects: (i) the direction of the experiential movement (to co-experiencing depression or from it) and (ii) the intensity of that movement.

The therapists' depictions suggested that their experiential reactions took different intensities, as inferred from their use of adjectives. Some, like Brian, experienced only a modest reaction in the direction of "Sharing depressive experience": "Internally, I agree with her that it can be like this." In other cases, a strong swing toward the client could even lead to experiential identification with the client and to the loss of therapists' awareness of their own needs and resources, as in Adam's case:

> My self-confidence was disappearing terribly fast. I was saying to myself: "What does my being here accomplish? I cannot do anything." Helplessness, helplessness.… This was the worst thing there.

On the other side, "Distancing from depressive experience", when the therapists differentiated experientially from their clients, could also take a less or more intensive form. Eva described just a modest experiential distance: "So I was wondering if she was going to manage it or not. When she was promising it here.… A strange feeling for me … a bit from a power position." Others distanced themselves from their clients so much that they lost the personal contact with those clients: "I catch myself thinking about shaking him: …'What the fuck?! What kind of problems do you have! If only you knew [what the real problems are]…!'" (FG2).

We identified three "process variants" of the Depression Co-experiencing Trajectory. The first variant, present in 13 of the 22 events, corresponded to the general sequence characterized by a balance of "Sharing depressive experience" and "Distancing from depressive experience". The remaining events can be subsumed into two variants in which one of the two poles dominated. The second variant, present in four events, primarily portrays therapists' "Distancing from depressive experience" with only slight "Sharing depressive experience." Therapists oscillated experientially further from their client's experience and resisted the tendency to be drawn into the depressive experience. They were able to handle their feelings of frustration and angriness toward the client without acting them out. The third variant, present in five events, represented the opposite pattern. It exhibited heavily the therapists' "Sharing depressive experience" with only slight "Distancing from depressive experience." Therapists could handle their experiences without noticeably polarizing themselves against their client's depressive experience. They managed to keep close to their client's experience without falling into co-experiencing the depression.

Discussion

Our resultant model of Depression Co-experiencing Trajectory can be used to organize existing empirical and theoretical literature by interconnecting different therapists' emotional responses within a coherent process model, which allows us to track the changes in therapists' experiences, to name the relations between them, and to connect them with the therapy's in-session microprocesses.

Empirical literature shows that the experiential movement toward and away from a depressed person has already been a phenomenon of much research and observation for some time now. Coyne (1976b) examined the interpersonal reactions elicited by exposure to a depressed individual and identified two basic reactions: depressed mood induction and rejection of the depressed person. These tendencies were identified in our research, too, as the categories "Sharing depressive experience" and "Distancing from depressive experience" categories. Although Coyne's research did not focus specifically on therapists, we can assume that these natural human reactions appear in them as well.

"Distancing from depressive experience" represents therapists' reaction to the disheartening and exhausting feelings evoked by the depressive client. Although King and Heller (1984) did not succeed in replicating Coyne's findings, Gurtman (1986) convincingly showed that rejection of depressed people is consistent across studies and methods. Copious studies have repeatedly shown that depressive people evoke rejecting or even hostile reactions in others (e.g., Gotlib & Robinson, 1982; Gurtman, Martin, & Hintzman, 1990; Marks & Hammen, 1982; Paukert, Pettit, & Amacker, 2008; Strack & Coyne, 1983). Green (2006) explains theoretically how a therapist's unmet self-regulatory needs may lead to feelings of frustration and rage toward a client, where rage is seen as indicative of these needs and hate as a force that can emancipate the therapist from the encumbrance of them. We can assume that the therapists' own unmet needs together with the client's excessive assurance seeking, which is a known factor specific to depression (Joiner, Metalsky, Gencoz, & Gencoz, 2001), result in the therapists' withdrawal reaction.

Additionally, the therapists' attunement (represented by the category "Sharing depressive experience") appears to be a stable and specific feature

described in empirical literature. The study by Rossberg, Karterud, Pedersen, and Friis (2007) on clients with personality disorders illustrates the positive relation between a client's depressive symptoms and the therapist's feelings of having lowered confidence and being overwhelmed. A phenomenon called "contagiousness of depression," (Coyne, 1976a) describing the transmission of emotional and behavioral expressions of depression (low mood, gloominess, anhedonia, pessimism, etc.) from the depressed person to another person, has been explored widely in different populations and settings. Signs of depression were not only found in longer relationships, either with roommates or intimate partners, but also arose after even a short and often indirect encounter with a depressive person. In the meta-analysis by Joiner and Katz (1999), 25 of 40 studies proved the existence of depression's "contagiousness" in close relationships, although better specification of the conditions for this phenomenon is needed in further research. Unfortunately, research describing this phenomenon in a therapeutic relationship is still lacking. We can, however, assume that similar processes can, as in other relationships, appear in a therapy setting.

Not all studies, however, support the phenomenon of a therapist's experiential attunement to a depressive client. Compared to the rejection response, mood induction research findings seem to be less reliable (Gurtman, 1986), tend to be diffuse, and their relation to rejection calls for deeper examination. For instance, in their study of behaviors that mediate interpersonal responses to depression, Stephens, Hokanson, and Welker (1987) also confirmed the existence of the rejection reaction but found no evidence of negative mood induction. However, this research was not conducted on real depressed clients but on confederates who only enacted being depressed. As a result, we can assume that deep automatic emotional attunement of the therapist to the existential experience of depression could not be established. The depressive behavior, on the other hand, provoked a rejection reaction and can be modeled.

Qualitative aspects of the above-mentioned phenomena in the therapeutic relationship were explored by McPherson, Walker, and Carlyle (2006), who described the experience of primary care counselors with resistant depressive clients and identified a range of emotions from caring responses (feeling empathy and worrying about clients) to negative ones (feeling powerless, a failure, deskilled, drained, frustrated, and in pain). Similar experiences appeared and were conceptualized in our analysis, but contrary to our results, McPherson et al. found that clients also had a positive impact on their therapist (enjoying the challenge, work satisfaction, and feeling "omnipotent"). Their study, however, did not distinguish between in-session and long-term experiences. Their findings suggest that the positive impact appeared during long-term therapy, and this may explain why it was not captured in our in-session data.

More complex descriptions of therapists' experiences can be found in theoretical literature. Wolf et al. (2013a, 2013b) presents a list of common interpersonal reactions which therapists exhibit to working with chronically depressed clients frequently. The list covers a wide spectrum of emotional states described in literature, ranging from being "sucked dry" to being "annoyed" or even "angry." All the 19 experiential states, except being "bored," also appeared in our data. Levenson's (2013) summary, however, does not classify the experiences nor looks for relations among them. In several other theoretical analyses, the relations between different kinds of therapists' experiences are more conceptualized, often into polarities. Wolf et al. (2013a, 2013b) describe the basic tension between the professional stance of a therapist and their personal emotional response to a suffering person. They described therapists' negative feelings (frustration, boredom, fear, anger, and hate) as "forces that pull therapists from their professional ideal" (Wolf et al., 2013a, 2013b, p. 4). Psychoanalytic theoretical understanding (McWilliams, 2011) can also be summarized into basic polarized countertransferential reactions to depressive clients. On one side ("complementary countertransference"), the therapist can possess fantasies of becoming "God" or the "Good Mother," or "the sensitive, accepting parent that the client never had" (McWilliams, 2011, p. 250). On the other side ("concordant countertransference"), the therapist can feel either "incompetent, blundering, damaging, and not good enough" (the introjective elements), or "hopeless, incompetent, demoralized, and futile" (the anaclitic elements) (McWilliams, 2011, p. 250). In practice, a therapist's experience is on the continuum between these two, just as the anaclitic and introjective types of depression exist in mixed ratios within each client.

Elliot (2013) described some "alliance difficulty markers," namely the category "withdrawal difficulty," which correspond with our results. We can associate our "Striving for symptom change" phase with his category "Self-consciousness and task refusal," in which a client refuses to perform suggested therapeutic activity, thereby evoking the therapist's anxieties about control and causing the therapist's frustration and annoyance. Furthermore, our phases "Sharing depressive experience" and "Distancing from depressive experience" can be

linked to Elliott's (2013) category "Covert withdrawal difficulties," in which a client disengages from the therapeutic process and evokes feelings of helplessness, leading to reactive frustration and anger in the therapist, or the therapist's emotional disengagement, leading to his or her boredom or sleepiness. Our theory supplements the above-mentioned findings by interconnecting the different emotional responses of therapists into a coherent process model, which allows us to track the changes in therapists' experiences, to name the relationships between them, and to connect them with the therapy's in-session microprocesses.

Although working with depressive clients burdens therapists significantly, relatively little is empirically known about the therapist's own experiential process during such treatment. Our theory allows us to interconnect the above-mentioned findings into a coherent process model and specify the nature of the therapist's load with these clients.

Why Are Therapists Unable to Learn from Their Previous Experience?

During the analysis, an unsettling question arose: Why do therapists repeat the Depression Co-experiencing Trajectory even after experiencing it many times before? Even the very experienced therapists in our sample reported repeatedly becoming trapped in the fixed relational pattern with depressive clients. Why were they unable to learn from previous contact with depressive clients and avoid this pitfall with later clients?

The concept of emotional contagiousness can be explained as the instant automatic imitation and synchronization of behavioral expressions of emotions (Hatfield, Cacioppo, & Rapson, 1993), which happen naturally and often without one's awareness. In their meta-analysis, Joiner and Katz (1999) substantiate that depression is "contagious" not only emotionally but rather as a complex of all its symptoms such as helplessness, tiredness, and anhedony, for example. Wolf et al. (2013a, 2013b, p. 2014) asserts that these "automatic" and "universal" emotional responses also manifest at the bodily level and states that, to a large extent, the therapist does not have a choice whether to contain or express them. In his neuroscience findings, Le Doux (1996) distinguishes this automatic emotional response transmitted through the amygdala from the emotions produced by the thalamus–neocortex pathway, which is slower, but enables more conscious processing.

Considering our results in the context of contemporary neuroscience research dealing with the interconnectedness of mind, brain, and relationships, we can notice further interesting similarities. Premotor cortical neurons called mirror neurons (Gallese & Goldman, 1998) display the same pattern of activity, both when the subject accomplishes certain goal-directed activity and when one observes the other performing the same action. This neuronal activity is "primarily of a practical nature … for it involves the direct pairing or matching of the bodies of self and other. There seems to be an immediate pairing" (Thompson, 2001, p. 9). Firing among the mirror neurons in the frontal and parietal regions of the cortex and related areas "creates a neural image of the mental state of another person.… The image of the other's intentional state is then used to initiate behavioral imitation and internal simulation" (Siegel, 2012, p. 176).

When we apply this perspective to our topic, we can say that a therapist's brain pairs itself immediately with the brain of the depressed client before the therapist can even notice or consciously influence it. The therapist's "internal simulation" of the client's mental state leads the therapist to co-experiencing the depression with the client. It seems that due to the automatic nature of such a response, therapists cannot avoid it even if they have already experienced and reflected on it in their previous work.

Acknowledging the fact that therapists are unable to avoid this reaction, it is important to assert that skipping this initial attunement to their clients might actually prove detrimental to the therapeutic process, as this reaction embodies the crucial "gateway of empathy" (Siegel, 2012, p. 165) and opens the "intersubjectivity of consciousness" (Thompson, 2001, p. 15). In her phenomenological analysis of empathy, Thompson (2001, p. 15) claims that "[in order] to perceive the Other, the open intersubjectivity essential to perceptual experience must be already there." As neuroscience shows, "sharing of basic appraisal and arousal processes establishes the fundamental way in which one person becomes connected to another within emotional relationships" (Siegel, 2012, p. 169). Higher nonverbal synchrony between client and therapist is associated with the client's self-reported quality of the therapeutic relationship, their experienced self-efficacy, and higher symptom reduction (Ramseyer & Tschacher, 2011).

When a therapist is attuned and conveys the understanding of a client's inner affective state, it provides the client with the experience that one's affective state can be seen and shared by another (Greenberg and Watson 2006). The therapist is reaching the other through attunement and bridging the interpersonal "abyss" (Francesetti & Roubal, 2013) created by the depression. This bridging is already healing, because it facilitates the development

of a parallel, prefrontally mediated process in the depressed person, as the "intimate, reciprocal human communication may directly activate the neural circuitry responsible for giving meaning, responding flexibly, and shaping the subjective experience of an emotionally vibrant life." (Siegel, 2012, p. 169) On the basis of current neuroscience findings, Greenberg and Watson 2006 also stress the right-hemispheric and nonverbal influence of a therapeutic relationship, which most effectively approaches depressive client's affective self-regulation processes largely without conscious awareness.

A therapist's attunement to depressive clients can be seen not only as risky for burnout but also reversely as natural and inevitable for the effective treatment of depression.

> Mirror properties in our brains enable us to imagine empathically what is going on inside another person. Internal simulation—the process of absorbing and resonating with others' internal states – is thought to be the first stage of compassion, or "feeling with" other persons. (Siegel, 2012, p. 165)

We assume that the danger resulting from relational attunement to a depressive client can be reduced when the therapists become more aware of the actual in-session processes. Emotional contagiousness, which is mainly an unconscious, spontaneous, and involuntary reaction could then be changed into empathy, a recognized therapeutic tool, which is more cognitive, aware, and can be further cultivated for the client's benefit. This assumption, however, goes beyond the presented model and needs to be verified in further research studies.

Limits and Future Research Implications

The definition of depression. In our study, depression was understood as encompassing a heterogeneous range of subtypes and presentations, as described by Wolf et al. (2013a, 2013b). Further specification of depression, either quantitative (use of rating scales for evaluating the seriousness of depression) or qualitative (specifying intra- and interpersonal dynamics), would enable us to distinguish the experiential reactions evoked in therapists by different depressive states and interpersonal dynamics. A promising step for a future study would, for example, be to distinguish between the two different developmentally determined subtypes of depression (Blatt, 2004): "anaclictic" or dependent depression (preoccupied by themes of abandonment and loss) and "introjective" depression (preoccupied by harsh self-criticism). Reis and Grenyer (2002) validated these depressive subtypes by indicating their differential attachment patterns. Hardy, Stiles, Barkham, and Startup (1998) distinguished these subtypes as underinvolved and overinvolved clients' interpersonal styles. He found that therapists used a more affective, relationship-oriented approach (which corresponds to our category "Sharing depressive experience") with overinvolved clients and more cognitive treatment methods (our category "Distancing from depressive experience") with underinvolved clients. Although in practice we typically encounter a continuum between these subtypes of depression (McWilliams, 2011), the responding therapist's reactions to differential intra- and interpersonal dynamics would need to be examined closely in further research.

Gender differences. Our study does not take into account clients' gender differences in coping with depression (Murakumi, 2002), which can evoke different reactions in therapists. Moreover, the reaction to depression is also influenced by the gender of the reacting person (Nolen-Hoeksema, 2001). According to Hammen and Peters (1978), men are more critical of depressive women and more willing to accept depressive men and vice versa. Howard et al. (1969) suggest that female therapists experienced unpleasant feelings with clients less often (but only 40% of clients in this study were depressive). On the other hand, McIntyre and Schwartz (1998) did not find a significant difference between female and male therapists in their countertransference reactions to depressive clients.

Participants. Data were collected from a broad spectrum of therapists to cover various psychotherapy approaches and different lengths of professional experience. This, on one side, allowed us to formulate a general and integrative model that can be applied across different groups of psychotherapists, since we agree with Wolf et al. (2013a, 2013b) that all therapists, regardless of orientation, are vulnerable to problematic emotions and can also use them as an important source of clinical data. On the other side, selecting only some clearly defined approaches, as Hardy et al. (1998) did with psychodynamic-interpersonal and cognitive-behavioral time-limited treatments for depression, would allow us to compare them and to connect therapists' coping strategies with their theoretical orientation. This, in turn, allows us to identify the specific strengths and weaknesses of each of the orientations (of the respective orientations) in managing therapists' own in-session experiences.

Similarly, distinguishing between novice and experienced psychotherapists would provide more specific information about the impact the years of

practice have on the therapist's experiencing and coping strategies and about the specific risks for burnout therapists encounter during their career. Brody and Farber (1996), for example, found that in comparison to experienced clinicians, novice therapists are more likely to feel that their emotions are too strong, too frequent, and need to be defended against. Also, when researching therapists' management of distracting self-awareness, Williams et al. (2003) distinguished novice therapists' strategies (more self-disclosure) from those of experienced therapists (more stopping techniques). The research of McIntyre and Schwartz (1998) similarly shows that with more years of professional experiences, therapists are less likely to be psychologically impacted by either dominance or difficulty with depressed clients.

Data creation. Gathering data from therapists limits the depiction of the therapy situation to only one perspective. Additionally exploring the client's in-session experiences, as Williams and Levitt (2008) did in their study of clients' experiences of difference with therapists, would allow us to describe in much richer detail the relational interplay, including the ongoing experiences of both sides. The general model of Depression Co-experiencing Trajectory obtained in our study could then serve as a basis for further, more complex research projects.

The method we used for data creation, i.e., qualitative analysis of recalled events, is listed by Hill and Knox (2009) as one of the recommended methods for researching the processing of the therapeutic relationship and is used for similar research designs (e.g., Abba, Chadwick, & Stevenson, 2008; Williams et al. 2003). However, this method of data creation is inevitably influenced by selectivity and distortion during the recollection process. The therapists might have focused on clients they had a special connection with or on clients with more severe symptoms. They might also have recalled therapy sessions that were especially difficult, complex, or that left them with a great deal to process emotionally and intellectually. Indeed, the feedback we received during the model validation after the last interview with the therapist chosen through theoretical sampling (see Phase 6 of the research procedure) suggested that the model fits very well with the therapist's experience with clients who stay depressive during the whole session, but not entirely with clients who get better during the session. This is why we limited our model to the therapists' in-session experiences with currently depressive clients. Focusing on these' experiences and omitting the longer course and wider context of therapy consequently prevented us from answering other interesting questions, such as: To what extent does the described in-session pattern of oscillation appear throughout the entire course of therapy? Did the pattern have a different evolution in therapies that were progressing, versus those in which the therapy did not progress well? Further research distinguishing different characteristics of clients, therapists, psychotherapeutic processes, and the recalled sessions is needed to develop variants of the model relevant to specific conditions.

For future research we can suggest the following procedures: Conducting research interviews immediately after sessions, as in a qualitative study of countertransference (Hayes et al., 1998), or collecting data by tape-assisted recall procedures, as, for example, in the exploration of therapists' reflections during therapy sessions (Rober, Elliott, Buysse, Loots, & De Corte, 2008), would help to explore all kinds of sessions as they naturally appear, better impart therapists' experiences evoked in a clearly described therapeutic situation, and focus on the in-session microprocesses specific to it. The task analysis procedure (Greenberg, 2007) could be used, and our current study could serve as the first, discovery-oriented model-building phase. The general model of Depression Co-experiencing Trajectory could then be validated and developed into a more detailed description of the in-session process of change seen from the perspective of a therapist's experience. Relating the process to the outcome would be the last step to see how therapists' own experience and coping with it influence the effectiveness of treatment of a client's depression. A process model and possibly also a quantitative tool gained from such research could have more general implications and could be used for exploring and describing therapists' experiences also with other client populations.

Conclusions: Compassion to Oneself

Therapist self-care is a "prerequisite for practicing psychotherapists" (Wolf et al., 2013a, 2013b, p. 276). An important part of such self-care lies in the way therapists respond to their own negative reactions. These reactions ought "not to be suppressed or rejected but instead should be acknowledged in a tolerant, self-accepting manner" (Wolf et al. 2013a, 2013b, p. 76). The presented model can support therapists in not blaming themselves for their negative reactions, and to instead value them as a source of clinically important information. Therapists can then understand their own experiences of helplessness, exhaustion, and hopelessness as an experiential movement toward the client, which

enhances the therapeutic relationship. At the same time, experiences such as impatience, angriness, and frustration can be understood as an experiential movement away from the client, which enables the therapist to take care of oneself and show the client an alternative perspective. We hope our findings can help therapists to cope with their negative feelings while conducting psychotherapy with depressive clients, to notice them mindfully, manage them self-compassionately, and use them to facilitate the therapeutic process.

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