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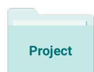

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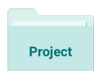

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Love Yourself as a Person, Doubt Yourself as a Therapist?

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Objective: There are reasons to suggest that the therapist effect lies at the intersection between psychotherapists' professional and personal functioning. The current study investigated if and how the interplay between therapists' ($n = 70$) professional self-reports (e.g., of their difficulties in practice in the form of 'professional self-doubt' and coping strategies when faced with difficulties) and presumably more global, personal self-concepts, not restricted to the professional treatment setting (i.e., the level of self-affiliation measured by the Structural Analysis of Social Behaviour (SASB) Intrex, Benjamin, 1996), relate to patient ($n = 255$) outcome in public outpatient care.

Method: Multilevel growth curve analyses were performed on patient interpersonal and symptomatic distress rated at pre-, post- and three times during follow-up to examine whether change in patient outcome was influenced by the interaction between their therapists' level of 'professional self-doubt' and self-affiliation as well as between their therapists' use of coping when faced with difficulties, and the interaction between type of coping strategies and self-affiliation.

Results: A significant interaction between therapist 'professional self-doubt' (PSD) and self-affiliation on change in interpersonal distress was observed. Therapists who reported higher PSD seemed to evoke more change if they also had a self-affiliative introject. Therapists' use of coping strategies also affected therapeutic outcome, but therapists' self-affiliation was not a moderator in the interplay between therapist coping and patient outcome.

Conclusion: A tentative take-home message from this study could be: 'Love yourself as a person, doubt yourself as a therapist'. Copyright © 2015 John Wiley & Sons, Ltd.

Key Practitioner Messages:
- The findings of this study suggest that the nature of therapists' self-concepts as a person and as a therapist influences their patients' change in psychotherapy.
- These self-concept states are presumably communicated through the therapists' in-session behaviour.
- The study noted that a combination of self-doubt as a therapist with a high degree of self-affiliation as a person is particularly fruitful, while the combination of little professional self-doubt and much positive self-affiliation is not.
- This finding, reflected in the study title, 'Love yourself as a person, doubt yourself as a therapist', indicates that exaggerated self-confidence does not create a healthy therapeutic attitude.
- Therapist way of coping with difficulties in practice seems to influence patient outcome.
- Constructive coping characterized by dealing *actively* with a clinical problem, in terms of exercising reflexive control, seeking consultation and problem-solving together with the patient seems to help patients while coping by avoiding the problem, withdrawing from therapeutic engagement or acting out one's frustrations in the therapeutic relationship is associated with less patient change.

Keywords: Therapist effects, Therapist Personal and Professional Selves, Patient Outcome, Multilevel Growth Curve Modelling

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The Therapist as a Professional and as a Person

It may be difficult to compare the work of psychotherapy with other professions because of its specific requirement that, to be of help to clients, the therapists must succeed in integrating their *professional* capacities and expertise with their *personal* attributes in a way that almost blurs the distinction between them. That is perhaps why neither—on the one hand—therapist professional qualifications, such as years of professional experience, amount or type of training, adherence to treatment protocols or competence in delivering interventions, nor—on the other hand—global personality traits or general emotional well-being, have been found to consistently predict psychotherapy process and outcome (Barber, 2009; Beutler *et al.*, 2004, Lambert & Barley, 2002; Tracey, Wampold, Lichtenberg, & Goodyear, 2014, Tschuschke *et al.*, 2014; Webb, DeRubeis, & Barber, 2010; Wolff & Hayes, 2009).

Based on a review of the literature on therapist characteristics, our suggestion is that professional qualifications (such as competence related to diagnostic assessment and technical skills) must merge in an optimal way with the personal and uniquely subjective aspects of therapists (i.e., their ways of being with others, attachment style, personality and non-verbal expressiveness) to create effective practice (Strupp & Anderson, 1997; Heinonen, Lindfors, Laaksonen, & Knekt, 2012). This claim corresponds logically to the current notion that it is not specific therapeutic interventions *or* common factors that account for the effect of psychotherapy but rather the interaction or even the *synergy* between the two (Nissen-Lie, 2013; Norcross & Lambert, 2011; Wampold & Imel, 2015). On the basis of our own previous research and other researchers' studies on what characterizes effective and ineffective therapists, in the current study, we aim to explore the potential interplay between some aspects of psychotherapists' professional and personal functioning.

Therapist Characteristics Influencing Therapy Outcomes

The individual therapist seems to matter as much to the effect of treatment as any of the other notable factors in psychotherapy, such as the therapeutic alliance (Wampold & Imel, 2015). That is, both the individual therapist and the quality of the alliance explain around 5–7% of outcome in studies portioning outcome variation (e.g., Baldwin & Imel, 2013; Benish & Imel, 2008, Laska, Gurman, & Wampold, 2014).

Hence, therapists seem to differ in effectiveness; however, what it takes to be a good therapist, who should enter training, how we should train therapists to work optimally and whether therapists get better at what they do over time are questions that await firm empirical answers. Recent studies show that therapists' personal and interpersonal qualities seem to be particularly relevant to psychotherapy outcome, for example, their facilitative interpersonal skills (Anderson *et al.,* 2009); their capacity for affirmation, responsiveness, genuineness and empathy with different types of clients (Bohart, Elliott, Greenberg, & Watson, 2002)—but also their being convincing and persuasive (Oddli & Rønnestad, 2012; Wampold, 2014); their ability to resist counter-aggression when confronted with devaluation and rejections by patients (Lambert & Barley, 2002; Safran, Muran & Eubanks-Carter, 2011; von der Lippe, Monsen, Rønnestad, & Eilertsen, 2008); and their ability to manage countertransference reactions (Hayes, Gelso, & Hummel, 2011). As already mentioned, thus far, these factors seem more important than more professional factors, such as practice experience, training, as well as adherence and competence, in distinguishing between therapists (Beutler et al., 2004; Tracey *et al.,* 2014; Wampold & Imel, 2015; Webb, DeRubeis, & Barber, 2010). Even though we have empirically based indications that many psychotherapists over time integrate their personal characteristics into their professional work (e.g., Rønnestad & Skovholt, 2013), we do not know *if* or *how* such integration may impact processes and outcomes of psychotherapy. We know little about how the relationship between psychotherapists' personal and professional functioning may impact professional role performance. On this background, we seek to explore how selected aspects of professional and personal characteristics interact in contributing to more or less change in patients.

Therapist Self-Perceptions

In order to examine the interaction between therapists' self-concepts as a person and as a therapist, we relied on measures of psychotherapist functioning as observed from the psychotherapists themselves. The value of self-report in psychotherapy has been questioned (see Dunning, 2005; Orlinsky, Rønnestad, & Willutzki, 2004). Despite this, associations between therapist self-appraisals and patient outcome have been reported in a number of recent studies applying therapist measures developed by the Society for Psychotherapy Research Collaborative Research Network (CRN) (Orlinsky & Rønnestad, 2005), collected via the large-scale survey *Development of Psychotherapists Common Core Questionnaire* (DPCCQ). This includes therapist self-assessed 'work involvement styles'; difficulties in practice; coping strategies; interpersonal functioning; in-session feelings; and quality of personal lives (Hartmann *et al.,* 2014; Heinonen et al., 2012; 2013; Nissen-Lie, Monsen, & Rønnestad, 2010; Nissen-Lie, Havik, Høglend, Monsen, & Rønnestad, 2013; Nissen-Lie *et al.,* 2013; Zeek *et al.,* 2012).

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Of particular interest to this study, two factors measured by the DPCCQ reflecting therapists' *difficulties in practice*, Professional Self-Doubt' (PSD) and 'Negative Personal Reaction' (NPR), were shown to be the most powerful, in terms of explained variance, therapist predictors of process and outcome in the same sample as was used in the current study (Nissen-Lie *et al.*, 2010; Nissen-Lie *et al.*, 2013). However, these factors were related to process and outcome in opposing ways; while NPR had a negative effect on alliance and was associated with higher levels of interpersonal distress during treatment, PSD had a beneficial effect with regard to early patient-rated working alliance and patient change in interpersonal distress. Due to the initially unexpected favourable effect of PSD, the factor was interpreted as indicating a therapists' healthy self-criticism and ability to be open, sensitive, reflexive and taking responsibility for relationship struggles in therapy, and not as a measure of justified concern about one's actual competence.

Nonetheless, why self-doubt is a constructive and beneficial aspect of a therapists' repertoire in treating clients is still an open question. With reference to this finding, Macdonald and Mellor-Clark (2014) argue that clinicians work more effectively when they are more conscious of challenges and uncertainties of their work and less 'blinded' by their own competence: 'Therapists who are more aware of their natural limitations, and more realistic about the likelihood of poorer client outcomes, are more alert to indications that their clients are "off-track", enabling them more frequently to resolve barriers to therapeutic progress'. Tracey et al. (2014) reason that PSD may 'encompass a critical evaluation of one's work from a disconfirming stance' (p. 225). The constructive consequence of a self-critical stance is also consistent with the thinking of Baltes and Smith (1990) who suggested an attitude of 'uncertainty' as one criterion of wisdom, and with Rønnestad and Skovholt (1991), who suggested 'awareness of the complexity of therapeutic work' (Rønnestad & Skovholt, 2013) as a characteristic of optimal professional development.

Interpersonal Theory and the Concept of Self-Affiliation

In planning this study, we asked what is needed in a therapist for professional self-doubt to be of benefit to the client and were reminded of the seminal Vanderbilt studies, which reported an empirical link between therapists' introjects and the interpersonal process and outcome in short-term psychodynamic psychotherapy (e.g., Henry et al., 1990). Referring to conscious and unconscious ways of treating oneself, the concept of the *introject* lies at the core of interpersonal theory (e.g., Sullivan, 1953; Leary, 1957). In this tradition, which is founded on both the object relational school within psychodynamic theory (e.g., Mahler, Pine, & Bergman, 1975) and the interpersonal circumplex model of personality (e.g. Leary, 1957), one assumes that a person treats oneself at the internal level in accordance with how he or she was treated by primary caregivers and treat others in accordance with this inner mental representation. If a person is treated predominantly with love, care and tolerance, an internalized way of treating oneself with care and nurture would result—which in turn creates a tolerant and warm approach to other people. In contrast, interpersonally critical and cold behaviour from parents or other caregivers would result in a harsh manner of treating oneself. Based on these models of personality, Benjamin (1996) created the Structural Analysis of Social Behaviour (SASB) methodology to describe and measure these structures and interpersonal patterns. The SASB instrument operationalizes intrapersonal and interpersonal dynamics as revolving around the two main dimensions of Affiliation and Dominance, creating eight distinct combinations (clusters), and as reflected in three surfaces: (a) the transitive surface (interpersonal actions towards others); (b) the intransitive surface (interpersonal reactions to others' actions against oneself); and (3) the introject (introjected actions directed towards oneself). This latter part of the instrument was used to assess therapists' ways of treating themselves as persons in the current study (see Figure 1 and Measures). Empirical evidence of a robust association between introject states and psychopathology is being built-up (see Bjerke, Solbakken, Friis & Monsen, in press; Halvorsen & Monsen, 2007). We are unaware of studies reporting a link between therapists' introjects and patient outcome, except for the Vanderbilt studies (e.g., Henry et al., 1990), in which the researchers hypothesized that the therapists' introject status would affect their interpersonal behaviour in a way that would provide corrections

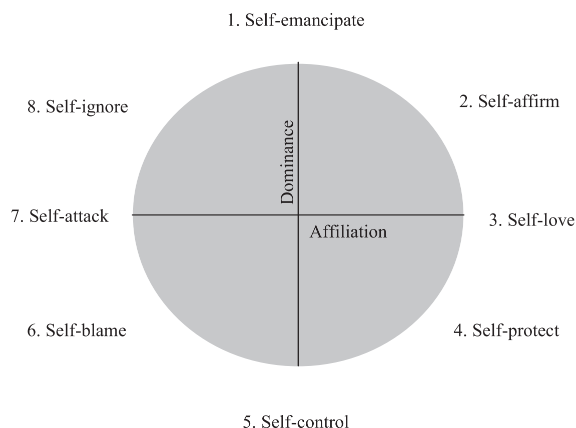

Figure 1. The introject surface of the simplified Structural Analysis of Social Behavior cluster model (Benjamin, 1996)

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to, or serve to reinforce, the patients' maladaptive introject states. The results demonstrated that therapists with more hostile and disaffiliative introjects engaged in a higher number of subtly hostile interpersonal behaviour towards patients, which in turn were correlated with more self-blaming behaviour and poorer outcome in patients.

Based on the above mentioned research, we anticipated that the therapists' level of personal self-affiliation may enhance the effect that professional self-doubt has on change in interpersonal distress. Self-doubt in the context of a tolerant and self-affiliative introject is different than in the context of a more disaffiliative introject, we hypothesized. This formed the basis of our first research question.

Moreover, we were also interested in examining how therapists' choice of coping strategies when faced with difficulties in psychotherapy practice would relate to patient outcomes. Therapists likely use an array of different ways of dealing with challenges in their therapeutic work, which are more or less conscious and intentional (Orlinsky & Rønnestad, 2005), and potentially affect the quality of their work. The DPCCQ survey package, which was used to tap the therapists' professional characteristics in this study, includes a questionnaire aimed at assessing therapist coping strategies. The item scales of this questionnaire were developed through a qualitative process of eliciting clinicians' narratives of coping strategies when experiencing difficulties in practice (Davis, Elliott, *et al.*, 1987a). These accounts formed the basis for constructing a questionnaire that was included in the DPCCQ (see Measures). The coping strategies assessed by the DPCCQ spans different categories such as *exercising reflexive control*, *seeking consultation*, *reframing the helping contract* and less commonly used strategies such as *avoiding the problem* or *acting out the frustration with the client* (Orlinsky & Rønnestad, 2005). The DPCCQ scales have been factor analysed into one factor containing positive aspects of coping (i.e., constructive coping) and one with more negative, maybe even destructive, elements (non-constructive coping or 'avoiding therapeutic engagement') (Orlinsky & Rønnestad, 2005); the former making part of a 'healing involvement style' while the latter is a component of 'stressful involvement' (Orlinsky & Rønnestad, 2005). The predictive validity of these factors have previously been tested in the Helsinki Psychotherapy Project (Knekt *et al.*, 2011); a study of 326 outpatients suffering from mood or anxiety disorders. In investigating the relative importance of both professional and personal therapist characteristics measured by the DPCCQ, it was demonstrated that the two factors, constructive and non-constructive coping, are related to alliance and outcome in short-term and long-term treatments (Heinonen *et al.*, 2012; 2013). In the current study, we examined the effect of constructive and non-constructive coping as predictors of patient outcome (see research question 2), as well as examining if an effect of coping may be moderated by the therapists' self-affiliation (research question 3), with the same logic as was applied when formulating research question 1.

Research Questions and Hypotheses

The following research questions were investigated:

1. Does therapists' self-affiliative introject status moderate the relationship between PSD and patient change in interpersonal distress? We hypothesized that PSD would have a more beneficial effect on outcome when therapists also reported higher levels of self-affiliation.
2. Does therapists' use of coping strategies when faced with difficulties in practice affect patient outcome? We hypothesized that constructive coping would affect outcome in a positive fashion, while non-constructive coping would have a negative impact.
3. Does therapist self-affiliation moderate a relationship between coping strategies and patient outcome?

METHOD

Participants

Patients

The data used in the study came from the Norwegian Multisite Study of the Process and Outcome of Psychotherapy (NMSPOP) (Havik *et al.*, 1995). As previously described (Nissen-Lie *et al.*, 2010; 2013), the NMSPOP is a naturalistic outpatient psychotherapy project involving 370 patients who were treated at 16 public outpatient clinics within the Norwegian public mental health care system, organized at eight different research sites. The treatments were influenced mainly by psychodynamic treatment models, although they were still rather eclectic and could be classified as treatment-as-usual, that is, no protocols or special supervision were used (see the section on Therapists below), except that three of the eight sites provided Affect Consciousness treatment (Monsen & Monsen, 1999). The patients were recruited from 1996 to 2000, and by the end of 2005, all treatments in this project had been terminated. The mean number of sessions in the NMSPOP was fairly large (52), which in part may be due to the relatively high level of clinical disturbance in the patient sample (see below). The patients were referred to public outpatient clinics for assessment and treatment of a wide range of clinical symptoms and disorders. The inclusion policy was liberal, so as to ensure a typical outpatient sample. Only patients with serious substance abuse problems, acute crises requiring hospitalization and psychoses were excluded from the study. Of the total

sample, 48% comprised patients suffering from at least one personality disorder. The analyses of patient outcome presented below were conducted on a subsample of patients ($n = 255$) who had provided a minimum of three measurements of the two outcome measures [Inventory of Interpersonal Problems (IIP) and Global Severity Index (GSI)], so as to allow for growth curve modelling (Hox, 2010). This subsample included 169 (74.4%) women and 58 (25.6%) men, whose ages ranged from 18 to 65 years, with a mean of 35.7 years [standard deviation (SD) = 9.52]. The most frequent Axis 1 DSM-IV diagnoses in this sample were anxiety disorders (67%; e.g., social phobia or generalized anxiety) and affective disorders (55.9%; e.g., major depression or dysthymia). Half (50.2%) of the patients met the criteria for at least one personality disorder. The level of psychosocial functioning at baseline, as measured by the Global Assessment of Functioning scale (Endicott, Spitzer, Fleiss, & Cohen, 1976), ranged from 20 to 85, with a mean of 57.6 ($SD = 8.9$).

Therapists

The therapists were assessed using the comprehensive self-report survey DPCCQ (Orlinsky *et al.*, 1999; Orlinsky & Rønnestad, 2005; see below). The therapist sample consisted of 70 psychotherapists [(46 psychologists, 14 psychiatrists, 8 physiotherapists specializing in Psychodynamic Body Treatment (see Monsen & Monsen, 2000) and 2 psychiatric nurses]. Their level of experience in practicing psychotherapy ranged from 0 to 28 years, with the mean being 10.0 years ($SD = 6.57$). Their caseload included in the study ranged from 1 to 11 patients, with the average being almost five patients each. The degree to which therapists were influenced by various theoretical orientations in their therapeutic work was measured by a five-point Likert scale, ranging from 1 (*not at all*) to 5 (*very much*), flexibly allowing for ratings of multiple orientations. Based on the therapists' responses to this questionnaire, the majority in the sample (78.3%) reported a psychoanalytic/psychodynamic *salient orientation*, which is defined as a rating of four or more on the five-point scale included in the DPCCQ. A substantial portion of therapists in the sample also reported having a salient orientation in the humanistic (29.4%) and/or cognitive (28.7%) treatment models.

Measures

Outcome Variables

Interpersonal Problems. The first outcome variable used was global interpersonal problems assessed using the Norwegian translation of the Inventory of Interpersonal Problems with 64 items (IIP-64) (Horowitz, Alden, Wiggins, & Pincus, 2000). The IIP-64 contains two types of items: 39 items follow the phrase 'It is hard for me to…' and the other 25 items describe 'Things that you do too much.' Each item was rated on a five-point scale ranging from 0 (*not at all*) to 4 (*extremely*). A total interpersonal distress score (IIP global) was calculated from the mean of the IIP-64 at pre-treatment, post-treatment and three times during follow-up (at 6, 12 and 24 months after treatment termination). This global score is interpreted as 'the best structural index of an individual's interpersonal adjustment' (Gurtman & Balakrishnan, 1998, p. 350). The test–retest reliability, internal consistency and construct validity of the IIP-64 have been demonstrated to be excellent (Horowitz *et al.*, 2000). This also includes the Norwegian translation of the instrument (Monsen *et al.*, 2006). The average IIP-64 global score in the sample at baseline was 1.49 ($SD = 0.54$, range 0.16–2.81).

Symptom Distress. The second outcome variable was symptom distress as measured by the revised Symptom Checklist-90 (Derogatis, 1983), which is a self-report questionnaire composed of 90 items tapping nine different symptom dimensions. The 90 items are rated from 0 (*not at all*) to 4 (*very much*). The responses to the items were averaged in the standard GSI gathered at pre-treatment, post-treatment and three times during follow-up. The GSI is regarded as well suited to represent patients' general psychopathology and psychological distress, and its sensitivity to change through psychotherapy has been demonstrated (e.g., Ogles, Lambert, & Masters, 1996). Clinical cut-off ranges for the GSI have been established in a number of studies of normative samples. Scores over 0.97 (with a confidence interval of 0.76–1.19) indicate severe psychological distress (Lambert, Burlingame, & Hansen, 1996). In the patient sample, the GSI at pre-treatment was 1.27 ($SD = 0.62$, range = 0.16–3.34), and 163 (63 %) of the patients in the present investigation started out as severely distressed (GSI $\geq$ 0.97).

Therapist Measures

Survey instrument; Development of Psychotherapists Common Core Questionnaire. The therapist variables were measured using the comprehensive self-reported DPCCQ questionnaire (Orlinsky *et al.*, 1999), which contains 370 questions from several questionnaires divided in subsections (describing professional training and experience, professional development, current experiences of therapy and personal characteristics). Responses to this battery of questionnaires have presently been gathered from more than 11 000 psychotherapists. Using data available at the time ($n = 4923$), Orlinsky and Rønnestad (2005) conducted principal component analyses on several of the DPCCQ subscales in order to reduce the measures to a manageable set and to uncover underlying factor structures which has generated the model of therapists 'work involvement' based on the scales describing therapists' current experiences of therapeutic work (Orlinsky & Rønnestad, 2005).

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In the current study, the factor scales of one type of difficulties in practice (PSD), and coping strategies, which are subdimensions of these 'work involvement styles', were used as independent variables.

Professional Self-Doubt. Professional self-doubt is a factor consisting of nine items included in the DPCCQ scale measuring difficulties in practice by means of statements describing typical challenges in psychotherapy practice. These difficulty types were originally identified through a qualitative research process in which the researchers constructed a consensual set of experimental categories that could reliably be applied to describe accounts of difficulties they experienced as clinicians (Davis *et al.*, 1987a). These categories were made into a scale of 21 statements and included in the DPCCQ following the question: *Presently, how often do you feel…* Responses are made on a six-point Likert-type scale ranging from 0 (*never*) to 5 (*very often*). Principal component analyses on the responses provided by 4923 psychotherapists to this questionnaire yielded three reliable factors, which were termed 'PSD', 'NPR' and 'frustrating treatment case' (FTC) (Orlinsky & Rønnestad, 2005). The first two were reproduced through factor analysis in the current sample of psychotherapists (Nissen-Lie *et al.*, 2010). Only PSD was investigated in the present study because of its unexpected association with higher patient alliance evaluations and therapeutic change that we wanted to explore in more depth in the current study. PSD reflects self-questioning about one's professional efficacy in treating clients and includes the following nine items: *Lacking in confidence that you might have a beneficial effect on a patient*; *Unsure how best to deal effectively with a patient; Distressed by powerlessness to affect a patient's tragic life situation; Disturbed that circumstances in your private life will interfere with your work*; *In danger of losing control of the therapeutic situation with a patient*; *Afraid that you are doing more harm than good in treating a client*; *Demoralised by your inability to find ways to help a patient*; *Unable to generate sufficient momentum*; *Unable to comprehend the essence of a patient's problems*. The factor obtained a high internal consistency score in the general sample of therapists (Orlinsky & Rønnestad, 2005), as well as in current sample (Cronbach alpha = 0.90).

Coping Strategies. Therapists' coping strategies were measured in the DPCCQ with a questionnaire of 26 items, based on qualitative accounts that emerged through a similar research strategy as the difficulty accounts (also developed by Davis et al., 1987b), following the question: 'When in difficulties, how often do you….'. Responses are made on a six-point Likert-type scale ranging from 0 (*never*) to 5 (*very often*). The questionnaire items were subjected to factor analysis in a larger Norwegian representative sample ($n = 1678$) yielding two factors which were termed, as in the larger CRN study: constructive coping and non-constructive coping/'avoiding therapeutic engagement (Orlinsky & Rønnestad, 2005). The factor structure found in this Norwegian, larger sample was similar to the structure of the international CRN data with the exception of three additional items, which loaded on the factor 'non-constructive coping' only in the Norwegian data set (see below). The coping factors obtained satisfactory reliability scores in the current sample ($n = 70$). See below for items in each of the coping factors.

Constructive coping (alpha = 0.72).

1. *Try to see the problem from a different perspective*
2. *Share your experience of difficulty*
3. *Discuss problem with a colleague*
4. *Consult relevant articles*
5. *Involve another professional*
6. *Review privately with yourself how the problem arose*
7. *Just give yourself permission to experience difficult or disturbing feelings*
8. *See whether you and your patient can together deal with the difficulty*
9. *Consult about the case with a more experienced therapist*
10. *Sign up for a conference*

Non-constructive coping (alpha = 0.60).

1. *Simply hope things will improve eventually*
2. *Criticize a client for causing you trouble*
3. *Seriously consider terminating therapy*
4. *Avoid dealing with the problem*
5. *Show your frustration*
6. ***Postpone the work of therapy***[1]
7. ***Step out of the therapist role in order to take some urgent action on a patient's behalf***
8. ***Make changes to the therapeutic contract with a patient***

The Coping Strategies Scale has demonstrated predictive validity in previous research; constructive coping predicted alliance and outcome in a positive manner and non-constructive coping ('avoiding therapeutic engagement') was negatively associated with alliance and outcome, as would be expected (Heinonen *et al.*, 2012; 2013).

Self-Affiliation. To use the psychotherapists' level of self-affiliation as a moderator in the study (see below), the therapist sample's responses to the Norwegian version (Monsen et al., 2007) of the SASB Introject Surface Long Form A (Benjamin, 1996) were used. This instrument

[1]Items in bold were part of this dimension only in the Norwegian sample ($n = 1678$).

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contains 36 items describing how one treats oneself as a person. In the original SASB questionnaire, respondents are asked to rate themselves at their 'best' and their 'worst'. In this study, however, the therapists were instructed to rate themselves as they usually are. Changing this instruction was perform to increase the probability of measuring more stable aspects of self-relatedness (Bjerke *et al.*, in press; Svartberg, Seltzer, & Stiles, 1996; Halvorsen & Monsen, 2007). The items of the SASB make eight clusters (cluster 1, 3, 5 and 7 comprising five items each; while cluster 2, 4, 6, and 8 comprise four items). These clusters form a circumplex within a two-dimensional space defined by the dimensions 'Affiliation' (horizontal axis) and 'Dominance' (vertical axis) (e.g., Leary, 1957; Figure 1). Item statements like: 'I think up ways to hurt and destroy myself. I am my own worst enemy' (cluster 7, self-attack) and 'I tenderly cherish myself' (cluster 3, self-love) are rated on a scale from 0 (*never*, not at all) to 10 (*always*, perfectly). The SASB Introject Surface has obtained acceptable reliability scores, and correspondence with external criteria supports the validity of the scale in clinical and non-clinical samples (Monsen *et al.*, 2007; Halvorsen & Monsen, 2007).

In the present study, the weighted cluster scores along the horizontal, self-affiliation, dimension of SASB were used (e.g., Bjerke *et al.*, in press) according to a calculation suggested by Pincus *et al.* (1998):

$$\begin{aligned} Self-affiliation = \; & 0\ x\ cluster1\ +\ 4.5\ x\ cluster2 \\ & +\ 7.8\ x\ cluster3\ +\ 4.5\ x\ cluster4 \\ & +\ 0\ x\ cluster5\ -\ (\text{min}us)\ 4.5\ x\ cluster6 \\ & -\ 7.8\ x\ cluster7\ -\ 4.5\ x\ cluster8. \end{aligned}$$

This operational definition of self-affiliation weights cluster 3 (self-love) and 7 (self-attack) the most (the latter in a negative way), before cluster 2 (self-affirm), cluster 4 (self-protect), cluster 6 (self-blame) and cluster 8 (self-neglect); the latter two in a negative way.

See Table 1 below for descriptive statistics and intercorrelations of the therapist variables used in this study.

Procedure

The study investigated two different outcome measures as dependent variables (GSI and IIP global). These data were collected before the start of treatment, at treatment termination and three times during follow-up: at 6, 12 and 24 months after treatment. The therapists completed the DPCCQ self-report survey a maximum of six times during the project period with one year interval. Like in the former studies on working alliance and outcome (Nissen-Lie *et al.*, 2010; 2013), the therapist scores of the second DPCCQ administration were used as the basis for analyses because some of the variables (e.g., coping strategies) were

Table 1. Descriptives and intercorrelations of the therapist predictors (*n* = *70*)

Therapist factors	M	*SD*	Min	Max	1	2	3	4
1 PSD	1.24	0.70	0.11	3.78	–			
2 CC	3.03	0.61	1.50	4.40	−0.19*	—		
3 NC	1.13	0.43	0.25	2.00	0.19*	0.13	—	
4 SASB_AFF	113.8	43.8	0.00	194	−0.36**	.28**	0.09	—

PSD = professional self-doubt. CC = constructive coping. NC = non-constructive coping. SASB_AFF = self-affiliation from Structural Analysis of Social Behaviour Intrex. SD, standard deviation.
**Correlation is significant at the 0.01 level (two-tailed).
*Correlation is significant at the 0.05 level (two-tailed).

not included in the first version. The SASB scores were collected when the therapists were enrolled in the study.

Note that there was no systematic time relationship between the assessments of the three outcome measures, DPCCQ Questionnaires and the SASB, owing to the continuing inclusion of patients and therapists into the project, so that the individual treatment processes had different starting points, which were not related to the therapist assessments.

Data Analyses

Multilevel Growth Curve Modelling

Multilevel growth curve analyses were performed on 255 patients treated by the 70 psychotherapists. Because repeated measures (Level 1) were nested within patients (Level 2), who were nested within therapists (Level 3), we used a three-level, hierarchically nested random effects growth model to analyse the effect of therapist predictors on change in IIP and GSI. A primary reason to use these methods is to account for non-independence in the data. Failure to account for data dependence could result in an underestimation of the standard errors (in this case of the therapist-level predictors), which could lead to in an inflated Type I error rate (Raudenbush & Bryk, 2002; Snijders & Bosker, 1993). Multilevel modelling (MLM) is also robust in allowing for missing observations or unequally distributed measurement waves per unit, which are typical problems in longitudinal, naturalistic psychotherapy research (Hox, 2002; Tasca, Illing, Joyce, & Ogrodniczuk, 2009). A therapists were treated as a random factor. That is, randomly distributed intercepts and slopes were fitted for each therapist in order to account for nesting.The multilevel growth curve analyses were performed on each of the two outcome measures; IIP total and GSI consecutively, using a 'time' variable and the therapist predictors examined in three different models. The 'time' variable reflected the measurement waves of 1–5 for the outcome measures (pre-treatment, post-treatment and three follow up measurements), which were log transformed (into the variable called 'LOGTIME') because

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the fit indices (e.g., 2LL; AIC) indicated a better fit for loglinear growth. This is a common procedure in psychotherapy research because change typically is steeper at the beginning (from pre-treatment to post-treatment) and then flattens during the follow-up period (Tasca *et al.*, 2009).

All models were estimated using maximum likelihood (ML) estimation procedure as recommended by, e.g., Hox (2010) when one has relatively large amounts of groups (in this case 70 therapists = 'groups') and the main interest is in fixed effects predictor analyses. Assumptions underlying MLM growth curve analyses for change, such as normally distributed residuals and homogeneity of variance, were assessed (Singer & Willett, 2003). In order to reduce multicollinarity and to aid the interpretation of the findings, particularly concerning interaction effects, the log transformed time variable (LOGTIME) and all predictors were centred around the mean, as recommended in the literature (e.g., Hox, 2010; Singer, 1998). The analyses were performed using the IBM SPSS software (version 21.0; IBM Corporation, Armonk, New York, USA). See results of the three models for both outcome measures summarized in Table 2.

Table 2. Results of multilevel modelling growth curve analyses: therapist predictors of outcome

Models	IIP	GSI
Model 1	Estimate/(S.E)	Estimate/(S.E)
Intercept	**1.22***(0.03)**	**0.88***(0.04)**
Fixed slope	**−0.57***(0.04)**	**−0.71***(0.07)**
PSD	−0.04(0.05)	0.009(0.06)
PSD*slope	**−0.18**(0.06)**	−0.04(0.07)
SASB_AFF	−0.00008(0.0008)	−0.001(0.0009)
SASB_AFF*slope	−0.0001(0.001)	0.0003(0.001)
PSD*Slope*SASB_AFF	−0.0035**(0.001)	−0.001(0.001)
Model 2		
Intercept	**1.24***(0.03)**	**0.87***(0.04)**
Fixed slope	**−0.53***(0.04)**	**−0.69***(0.05)**
CC	0.09(0.06)	−0.07(0.08)
CC*Slope	**−0.14*(0.07)**	−0.06(0.15)
SASB_AFF	−0.0002(0.0008)	−0.0001(0.0009)
SASB_AFF*Slope	−0.0001(0.0009)	0.0002(0.001)
CC*Slope*SASB_AFF	−0.001(0.001)	0.00005
Model 3		
Intercept	**1.23***(0.02)**	**0.87***(0.04)**
Fixed slope	**−0.57***(0.04)**	**−0.69***(0.05)**
NC	0.009(0.008)	−0.04(0.09)
NC*Slope	0.03 (0.09)	**0.23*(0.11)**
SASB_AFF	−0.0002(.002)	−0.0007(0.0009)
SASB_AFF*Slope	0.0003(0.0001)	0.0001(0.001)
NC*Slope*SASB_AFF	0.00001(0.001)	0.00008(0.002)

PSD = professional self-doubt. CC = constructive coping. NC = non-constructive coping. SASB_AFF = self-affiliation from Structural Analysis of Social Behaviours Intrex. IIP = Inventory of Interpersonal Problems. GSI = Global Severity Index.
*$p \leq 0.05$.
**$p \leq 0.01$.
***$p \leq 0.001$, $n = 70$. Estimation method: maximum likelihood; bold characters indicate significant results. All predictors, including the slope (LOGTIME) are centred, so in the models, the intercepts represent the mid-score.

Results

Multilevel Modelling Growth Curve Procedure, Inventory of Interpersonal Problems

Model 1a: Professional Self-Doubt and Self-Affiliation. Professional self-doubt had a beneficial effect on change in IIP, while self-affiliation alone did not relate to change. As hypothesized, there was a significant interaction between PSD and self-affiliation ($B = -0.0034$, $p < 0.01$). See Figure 2 below for an illustration of this finding with three lines representing change in IIP (y-axis) obtained by patients treated by therapists with high, average and low levels of self-affiliation and with different levels of PSD (x-axis.). Negative values of IIP (y-axis) indicate more change, and vice versa. As can be inspected, the most change was obtained by patients treated by therapists who were high on both PSD and self-affiliation, while the least change was observed in those treated by therapists who combined low scores of PSD with high scores on self-affiliation.

Model 2a: Constructive Coping and Self-Affiliation. The model including the factor constructive coping and self-affiliation showed that constructive coping had a beneficial effect on change in interpersonal distress ($B = -0.19$, $p < 0.01$). Self-affiliation did not moderate the relationship between coping and change in IIP.

Model 3a: Non-Constructive Coping and Self-Affiliation. Neither non-constructive coping nor its interaction with self-affiliation affected patients' change in interpersonal distress.

Multilevel Modelling Growth Curve Procedure, Global Severity Index

Model 1b: Professional Self-Doubt and Self-Affiliation. Neither PSD and self-affiliation nor the interaction between PSD and self-affiliation affected patients' change in GSI, as shown in this model.

Model 2b: Constructive Coping and Self-Affiliation. Neither constructive coping nor its interaction with self-affiliation affected patients' change in GSI, as found in this model.

Model 3b: Non-Constructive Coping and Self-Affiliation. The model including the factor non-constructive coping and its interaction with self-affiliation showed that non-constructive coping had a deleterious effect on change in GSI ($B = 0.19$, $p < 0.01$). Self-affiliation did not moderate the relationship between coping and change in GSI.

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DISCUSSION

From our own previous research, we know that therapists' level of PSD has been demonstrated to be a strong, positive predictor of early patient-rated alliance and patient change in naturalistic psychotherapy (Nissen-Lie *et al.*, 2010; 2013). In the current study, we hypothesized that this effect might be influenced by the psychotherapists' level of self-affiliation (Benjamin, 1996; Pincus *et al.*, 1998); a stable core of tolerance and nurturance in the personal self that we expected would increase the benefit of professional self-doubt in therapeutic effectiveness. Our findings provided preliminary support for this idea. Interestingly, in our analyses, it was demonstrated that self-affiliation did not on its own affect change, neither with regards to patient general interpersonal distress nor to their global symptom distress. This substantiates the notion that more global aspects of a therapists' personality structure—that are not specific to therapeutic situations—are not predictive of outcome, probably because they are too distant from the therapeutic situation to be relevant (Beutler *et al.*, 2004; Wolff & Hayes, 2009). On the other hand, as we hypothesized, the *interaction* between PSD and self-affiliation predicted change significantly. Therapists who reported more self-doubt in their work facilitated change in patient interpersonal distress to a greater extent if they also reported to have a self-affiliative introject. Incidentally, those who combined low scores on PSD with higher scores of self-affiliation contributed to the *least* change. The findings imply that a healthy self-critical stance is an ingredient of successful professional role performance but that treating oneself as a person with care and nurturance but lacking capacity to critically evaluate (i.e., doubt) one's therapeutic work, is not. The combination of personal self-affiliation and PSD seems to pave the way for an open, self-reflective stance that allows psychotherapists to respect the complexity of their work, and, when needed, to correct the therapeutic course in order to help clients more effectively with their challenges (e.g., Macdonald & Mellor-Clark, 2014; Rønnestad & Skovholt, 2013).

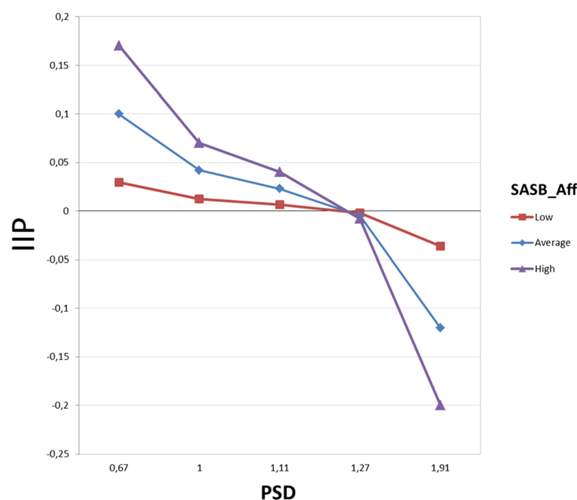

Figure 2. Change in Inventory of Interpersonal Problems (IIP) (y-axis) for patients treated by therapists with increasing scores (i.e., 20th, 40th, 50th, 60th and 80th percentiles) on professional self-doubt (PSD) (x-axis) and with low (red line), medium (blue line) or high (purple line) levels of self-affiliation from Structural Analysis of Social Behavior (SASB_AFF). Note that the negative numbers on IIP indicate greater change

A contrast to professional self-doubt may be a sense of exaggerated self-confidence, which likely arises as a defense against feelings of incompetence or lacking in therapeutic mastery; feelings most therapists encounter in their professional work. The concept of 'premature closure' has been suggested for the unconscious or preconscious defensive processes that therapists engage in when not tolerating feelings of incompetence in their work (Skovholt & Rønnestad, 1992). These processes may find their expression in different ways, such as in (a) misattribution (e.g., faulty explanation for client drop-out); (b) distortion (e.g., erroneous interpretation of client aggression as merely a transference reaction, where external observation suggests otherwise); and/or (c) dysfunctional reduction of the complexities of therapeutic work when difficulties are encountered (e.g., overly simplistic case formulations) (Rønnestad & Skovholt, 2013). The current findings suggest that combinations of professional and personal functioning in psychotherapists produce distinguishable interactional patterns that influence patient outcome.

Furthermore, in the current study, we found that therapists' use of coping strategies when faced with difficulties in practice also affected therapeutic outcome. As hypothesized based on the nature of these constructs (Orlinsky & Rønnestad, 2005) and from previous findings of the Helsinki Psychotherapy Project (Heinonen *et al.*, 2012), constructive coping strategies were associated with more reduction in global interpersonal distress, while non-constructive coping ('avoiding therapeutic engagement') negatively affected the rate of change in patient symptom distress. Therapists' self-affiliation was not a moderator in the interplay between therapist coping strategies and patient outcome. Hence, the effect of coping remained uninfluenced by the nature of the therapist personal self-relatedness.

Based on these findings, we may infer that patients are better off meeting therapists who can allow themselves to report higher levels of self-doubt in their clinical work because of a more acceptant and less attacking way of treating themselves as persons. Also, when therapists generally cope with difficulties by dealing *actively* with the problem, in terms of exercising reflexive control, seeking consultation and problem-solving together with the patient (Orlinsky & Rønnestad, 2005), this seems to help

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patients in reducing their general interpersonal distress. In contrast, when they cope with their struggles by avoiding the problem, withdrawing from therapeutic engagement or acting out their frustrations in the therapeutic relationship, this is associated with less change in symptomatic distress for their patients. The fact, however, that non-constructive coping was unrelated to patient change in interpersonal distress could be due to several factors other than it being irrelevant in creating an atmosphere in which reduction of interpersonal problems can be achieved. First, the internal consistency of the dimension is relatively low considering the number of items; second, semantically, the factor consists of items that address ways of coping that may be fruitful at times (and detrimental at other times), depending on the specific therapeutic situation. This is further discussed below.

Limitations

We should note that a limitation with this study is that the associations between therapist professional/personal functioning and outcome were not contextualized in specific psychotherapy patient–therapist dyads. Therapists most likely struggle with and cope differently with each patient they see, because unique aspects of their psychological functioning are elicited and will in turn affect the patients' functioning in a reciprocal transaction. This notion corresponds to what Stiles and colleagues (1998, 2009, 2013) have termed therapist 'appropriate responsiveness', referring to therapists' ability to adjust their interpersonal responses to the current state of the client and the interaction (Hatcher, in press). The therapists' level of appropriate responsiveness is not easy to measure (see Hatcher, in press); however, we may speculate from our finding that PSD, in the context of a nurturing introject, may pave the ground for it. Nonetheless, we are limited by the fact that these concepts were measured across a range of patients and different clinical situations. This is a general limitation of studies that map therapist characteristics against standard outcome measures and has prompted McLeod (2014) to formulate the following critique: (In such a research strategy)…'the therapist is conceptualized as a static entity rather than as an intentional actor operating in a social context' (p. 206). Moreover, the therapists' coping strategies in this study were predefined strategies (but based on an in-depth qualitative research process) and tapped what therapists have conscious access to. This of course does not preclude the possibility that unconscious processes may impact what therapists become aware of and are able to report. One may speculate that what is more relevant in terms of the quality of the therapy process is not the therapists' *conscious* coping strategies but rather their unconscious ways of coping (or defenses) which are, per definition, difficult to measure.

More generally, this is a naturalistic study with different levels of patient pathology, therapists of varying experience levels, little constraint as to what type of psychotherapy was offered, and so the patients received treatments of different types and lengths. As is often noted in comparing randomized controlled trials with naturalistic designs, the disadvantage of one is the advantage of the other. In this case, the naturalistic nature of the data, although creating problems when disentangling cause from effect, possesses a strength in that the findings are more generalizable to general clinical practice and hence, perhaps more feasible for practicing therapists to be informed by and use as basis for their self-reflections.

Implications and Conclusion

The findings suggest that therapeutic outcomes are influenced by what therapists experience as difficult in practice and the way they cope with these difficulties as professionals. Moreover, how they treat themselves as *persons* seems to influence this relationship. To some degree, our findings support the proposal that the therapist effect lies at the intersection between therapists' professional and personal selves.

The findings indicate that there is a link between therapist self-report and patient outcome, a link that has been hard to establish in previous studies (e.g., Anderson *et al.*, 2009), and for good reasons: there is a leap from therapists' accessible self-perceptions to patients' interpersonal and symptomatic distress experienced through treatment and post-treatment. Nonetheless, some mechanisms suggesting ways in which these factors may be linked are indicated by these findings. It is probable that therapists serve as a role model for their clients to internalize, which they take with them after the end of treatment, as an internal image to use in situations of distress (e.g., Halpern, 2003). When treated by therapists who can allow themselves to reflect on their share in difficulties that arise in the therapeutic relationship, but from a nurturing stance within them, patients may use this as a working model in their everyday struggles and adapt their coping when in distress, but without judging themselves. This is a notion that teachers and supervisors should make use of in trying to foster an atmosphere with their students and in clinical supervision that is characterized by tolerance for not knowing, embracing ambiguity and containing one's shortcomings and limitations without fear of 'losing face' or authority, maybe by being a role model to students themselves.

To some extent, we may suggest that the interplay between *how therapists treat themselves as a person* and *how they feel about a patient* during treatment affects patient outcome. More broadly, we recommend that this notion be incorporated in therapist training, supervision and

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therapists' everyday self-reflection. Tentatively, the 'take home message' from this study could be formulated with the following words: 'Love yourself as a person, doubt yourself as a therapist'.

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