

The Contribution of the Quality of Therapists' Personal Lives to the Development of the Working Alliance

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Research suggests that the *person* of the psychotherapist is important for the process and outcome of psychotherapy, but little is known about the relationship between therapists' personal experiences and the quality of their therapeutic work. This study investigates 2 factors (Personal Satisfaction and Personal Burdens) reflecting therapists' quality of life that emerged from the self-reports of a large international sample of psychotherapists ($N = 4,828$) (Orlinsky & Rønnestad, 2004, 2005) using the Quality of Personal Life scales of the Development of Psychotherapists Common Core Questionnaire (Orlinsky et al., 1999). These factors were investigated as predictors of alliance levels and growth (using the Working Alliance Inventory) rated by both patients and therapists in a large (227 patients and 70 therapists) naturalistic outpatient psychotherapy study (Havik et al., 1995). The Personal Burdens scale was strongly and inversely related to the growth of the alliance as rated by the patients, but was unrelated to therapist-rated alliance. Conversely, the factor scale of therapists' Personal Satisfaction was clearly and positively associated with therapist-rated alliance growth, but was unrelated to the patients' ratings of the alliance. The findings suggest that the working alliance is influenced by therapists' quality of life, but in divergent ways when rated by patients or by therapists. It seems that patients are particularly sensitive to their therapists' private life experience of distress, which presumably is communicated through the therapists' in-session behaviors, whereas the therapists' judgments of alliance quality were positively biased by their own sense of personal well-being.

Keywords: therapist effects, therapist personal characteristics, alliance quality, alliance development, multilevel growth curve modeling

The notion that the psychotherapist as an individual is important for psychotherapeutic outcomes stems in part from the well-known and frequently cited finding of meta-analyses that therapy outcome appears to be less related to the use of different therapy methods associated with established schools of therapy, and significantly related to differences between the individual psychotherapists providing the therapy (Benish, Imel, & Wampold, 2008; Blatt, Zuroff, Quinlan, & Pilkonis, 1996; Huppert et al., 2001; Kim, Wampold, & Bolt, 2006). Moreover, in efforts to identify the characteristics in therapists that promote treatment success or failure, the studies to date suggest that experience level, type of training, theoretical

orientation, and so forth have limited value in distinguishing between more or less successful therapists (Beutler et al., 2004; Dunkle & Friedlander, 1996; Sandell et al., 2007; Skovholt & Jennings, 2004; Strupp & Hadley, 1977). Instead, therapists' interpersonal qualities appear to be more relevant, such as their facilitative interpersonal skills (Anderson, Ogles, Pattersen, Lambert, & Vermeersch, 2009); their ability to be affirmative, responsive, and empathic (Bohart, Elliott, Greenberg, & Watson, 2002; Najavits & Strupp, 1994); their ability to resist counteraggression when confronted with devaluation and rejections by patients (von der Lippe, Monsen, Rønnestad, & Eilertsen, 2008); and their

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interpersonal functioning in their personal lives (Dunkle & Friedlander, 1996; Hersoug, Høglend, Havik, von der Lippe, & Monsen, 2009b). Hence, although therapists are professional helpers, it may be that their personal characteristics are more important than their professional qualifications in determining their therapeutic capabilities. This suggestion echoes the statements of Rosenzweig (1936), Strupp (1958), and Rogers (1957, 1961), who emphasized that studying the personal characteristics of psychotherapists is necessary in order to understand patient development in psychotherapy.

The Therapist as “Subject”

Although the need to study the impact of psychotherapists' personal lives has an empirical basis, it also builds on a theoretical rationale. Originally, even very different schools of therapy, such as psychoanalysis, behavioral, and cognitive-behavioral therapy, emphasized therapeutic techniques over the therapeutic relationship and the contribution of the therapist as an individual to promoting change (Gelso & Hayes, 2007). The patient was considered the only subject, and the therapist was considered a neutral observer, a “social reinforcement machine” or a professional who carried out different techniques (Goldfried & Davila, 2005). Provided that the therapist was properly trained in a particular treatment method, most theoretical orientations viewed the therapist as being interchangeable in providing psychotherapy to a particular patient. However, developments in psychotherapy theory (Aron, 1996; Benjamin, 2004; Mitchell, 1993; Renik, 1993; Stolorow, Brandchaft, & Atwood, 1987), coupled with advances in psychotherapy research (Safran, 2003; Wampold, 2001, 2007), have rendered this concept of psychotherapy somewhat outdated. This view of psychotherapy does not take into account the mutuality of psychotherapy exchanges, and the influence of the therapist's personality, interpersonal style, and even his or her personal life (Norcross & Lambert, 2011). This study explores potential ways in which such factors may affect the therapeutic process.

The Impact of Therapists' Personal Lives on Therapist Functioning

Psychotherapists' personal life experiences have previously been examined in several notable studies. Therapists' reports of their work stresses and satisfactions, the effect that conducting therapy has on their own life, and vice versa, their personal motives to become a psychotherapist, and their professional development have all been investigated (e.g., Guy, 1987; Guy & Liaboe, 1986; Henry, Sims, & Spray, 1971, 1973; Holt & Luborsky, 1958; Orlinsky & Rønnestad, 2005; Rønnestad & Skovholt, 2012).

A series of studies by James Guy and colleagues (e.g., Guy & Liaboe, 1986; Guy, Poelstra, & Stark, 1989) investigated the relationship between therapists' professional and personal lives. For example, Guy et al. (1989) conducted a survey of 749 practicing psychologists in order to assess the impact of their personal distress on the quality of patient care (as assessed by the therapists themselves). A total of 74.3% of these therapists reported experiencing “personal distress” during the previous 3 years. Of those, 36.7% indicated that it had negatively affected the quality of their work, and 4.6% admitted that it had resulted in inadequate treatment for their patients (Guy et al., 1989).

In another large-scale survey of 552 practicing psychologists, Sherman and Thelen (1998) explored both work factors and life events that triggered distress in psychotherapists, and the effect that this distress had on their professional actions, as judged by the practitioners themselves. They found a strong link between distress and impairment in terms of both life events and work factors, with personal relationship problems and encounters with difficult clients eliciting the most distress in the therapists. The authors also found that therapists with more practice experience reported less work-related distress and subsequent professional impairment. The researchers assumed that the more seasoned therapists had acquired coping skills and increased self-confidence, which helped them to reduce the amount of distress they felt. Interestingly, with regard to the distress related to personal life events, professional experience did not help reduce resulting professional impairment (Sherman & Thelen, 1998).

A more recent study examined the relationship between therapists' self-reports of their difficulties in practice, their coping strategies when faced with difficulties, their intersession experiences, and their quality of life, using items probing therapists' stress levels and private life satisfaction from the same questionnaire that was used in this study (Schröder, Wiseman, & Orlinsky, 2009). Schröder et al.'s (2009) findings indicate an intricate dynamic between therapists' professional and personal experiences. A positive relationship was found between the therapists' total experiences of difficulties in practice and reports of stress in their private lives, whereas a negative association was found between work difficulties and life satisfaction. The occurrence of increased stress in one's personal life was associated with the tendency to use avoidant coping strategies when facing difficulties in therapy practice. However, greater life satisfaction was associated with an increased likelihood of engaging in constructive coping strategies as a therapist, such as trying to see one's problem from a different perspective or discussing the problem with a colleague (Schröder et al., 2009).

Although these studies clearly highlight the relevance of the therapists' personal experiences in their work as therapists, none of them actually linked such experiences to psychotherapy process and outcome data obtained from outside the therapists' own perspectives. In this study, we explore whether or not therapists' reports of stresses and satisfactions indeed affect the degree to which both patients and therapists perceive that they have a working alliance and how it develops over time.

The Working Alliance: Concept, Therapist Effects, and Therapist Predictors

It has been widely demonstrated that the working alliance is a reliable predictor of psychotherapy outcomes (Flückiger, Del Re, Wampold, Symonds, & Horvath, 2012; Horvath, Del Re, Flückinger, & Symonds, 2011; Lambert & Ogles, 2004; Norcross & Lambert, 2011). One of the most common conceptualizations of the working alliance today is Bordin's (1979, 1994) model, in which the alliance is defined as comprising an emotional bond between therapist and patient, reflecting mutual trust, liking, and appreciation, and the extent to which they agree on the tasks and goals of therapy. This model has been operationalized in the commonly applied Working Alliance Inventory (WAI; Horvath &

Greenberg, 1989), which was used to measure the alliance in this study.

The last years have seen an increase in studies examining therapist effects on the process and outcome of psychotherapy, that is, the effect of a given therapist as compared with another therapist (see Baldwin & Imel, 2013, for an excellent review of these studies). Averaging across studies (e.g., Crits-Christoph et al., 2009; Dinger, Strack, Leichsenring, Wilmers, & Schauenburg, 2008; Marcus, Kashy, & Baldwin, 2009; Nissen-Lie, Monsen, & Rønnestad, 2010; Owen, Rhoades, Stanley, & Markham, 2011;), Baldwin and Imel (2013) found that approximately 9% of the variability in alliance scores is associated with therapists, but the effects varied a great deal from study to study (from almost 0% to 33%). In short, there are reasons to believe that therapists differ in their ability to build a strong working alliance with their patients and that research needs to devote itself to study the nature of these differences. In a previous study, Baldwin, Wampold, and Imel (2007) found that the therapist variability, not the patient variability, in alliance scores predicted patient outcome. The results implied that a patient who is seeing a therapist who, on average, obtains lower alliance scores from his or her patients would likely have gained more from therapy had he or she seen a therapist with a higher average alliance score, regardless of the patient's own alliance rating. This makes a strong case for the study of what characterizes those who obtain sustainable working alliances with clients, professionally and personally.

In one of the earlier studies on this, Dunkle and Friedlander (1996) looked at the associations between therapists' personal characteristics and the quality of their working alliances with patients. They found that therapists' levels of comfort with closeness, their perception of social support, and the quality of their private relationships contributed positively to the bond component of the early alliance, as rated by their patients. Conversely, the level of self-directed hostility in therapists was inversely related to their patients' evaluations of the emotional bond. The same study failed to find an expected link between therapists' professional work experiences and alliance quality as represented by the tasks and goal components of the WAI (Dunkle & Friedlander, 1996). In a more recent study, which used data from the same project as this study does, Hersoug et al. (2009b) observed a negative impact of therapists' self-reported interpersonal problems of the cold/detached type, measured by the Inventory of Interpersonal Problems (IIP-64; Horowitz, Alden, Wiggins, & Pincus, 2000) on both patient-rated and therapist-rated working alliance scores. Hersoug et al. also revealed that certain therapist characteristics display divergent associations to the working alliance, according to the rater's perspective. For instance, patient evaluations of the working alliance were related to the therapists' more positive perception of their mother's care up to adolescence, but this variable did not affect the therapist-rated alliance.

Studying therapist qualities, some researchers have noted that it is difficult to find a link between therapists' general emotional well-being or adjustment and psychotherapy processes or outcomes (Beutler et al., 2004). For example, Wolff and Hayes (2009) did not find a relationship between therapists' general emotional well-being and their working alliance with clients, but revealed that therapists' negative emotions toward clients were associated with poorer working alliances. As discussed by Wolff and Hayes, the lack of influence of the therapists' general well-being might

have been due to the distal nature of this variable and that some therapists may in fact be able to effectively manage their inter- and intrapersonal stress so that it does not unfavorably affect therapy.

We were prepared to find that the therapists' quality of life would be too remote a variable to exert an influence on either the patients' or the therapists' experiences of their alliance in therapy sessions. We have previously studied therapist factors pertaining directly to the therapists' daily therapeutic work developed by the Society for Psychotherapy Research Collaborative Research Network (Orlinsky & Rønnestad, 2005) in creating and using the multifaceted and large-scale survey battery *Development of Psychotherapists Common Core Questionnaire* (DPCCQ; Orlinsky et al., 1999). Several of the DPCCQ factors reflecting therapist work-related self-perceptions showed strong associations with early patient-rated alliance (Nissen-Lie et al., 2010) and patient- and observer-rated outcome (Nissen-Lie, Monsen, Ulleberg, & Rønnestad, 2013). Specifically, we found that a difficulty factor called "Professional self-doubt," which denotes doubts about one's professional efficacy (Orlinsky & Rønnestad, 2005), was positively associated with early patient-rated alliance and had a beneficial effect on change in interpersonal distress. Conversely, a different factor called "Negative personal reaction," which reflects negative emotions and deficient empathy toward patients, was found to be linked to lower alliance levels and increased levels of patient interpersonal distress. These findings suggest that therapists' experiences of themselves and of their therapeutic work are somehow expressed in their in-session behaviors.

Rationale of the Present Study and Research Questions

This study moved from the realm of therapists' professional self-perceptions to their personal life experiences and the potential impact that their quality of life has on their working alliances across patients' first 40 sessions of therapy, and as assessed by both patients and therapists. We first explored whether or not therapists differ in their ability to develop working alliances with their patients over time, as rated by patients and therapists. Second, we wanted to explore whether or not the therapists' self-assessed quality of life is related to their working alliance level and working alliance growth. We investigated the following two research questions:

1. Are there significant differences between therapists in patient-rated and therapist-rated working alliance scores over time?
2. Is there a relationship between therapists' quality of life and alliance levels/alliance development as rated by patients and therapists?

Method

Design and Treatment

Data from the Norwegian Multisite Study of the Process and Outcome of Psychotherapy (NMSPOP; Havik et al., 1995) were used in this study. The NMSPOP is a naturalistic outpatient psychotherapy project following 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 in nature (see the Therapists section below). Two 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 had been terminated.

The therapists in this study were assessed using the comprehensive self-report survey package DPCCQ (Orlinsky et al., 1999; Orlinsky & Rønnestad, 2005). They completed the DPCCQ a maximum of six times as part of the longitudinal study.

Participants

Patients. The patients in the NMSPOP were ordinary patients 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. Almost 50% of the total sample comprised patients suffering from at least one personality disorder.

The analyses of patient-rated alliance scores presented below were conducted on a subsample of patients ($n = 227$) who had provided a minimum of three measurement waves of alliance scores, so as to allow for growth curve modeling (Hox, 2010). This subsample included 169 (74.4%) women and 58 (25.6%) men, whose ages ranged from 18 to 65, with a mean of 35.7 ($SD = 9.52$). The most frequent Axis I *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (*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%) the patients met the criteria for at least one personality disorder (PD) (29.2% from Cluster A; 20.4% from Cluster B; 84.1% from Cluster C, 2.7% were non-specified PDs¹). The level of psychosocial functioning at baseline, as measured by the Global Assessment of Functioning (GAF) scale (Endicott, Spitzer, Fleiss, & Cohen, 1976), ranged from 20 to 85, with a mean of 57.63 ($SD = 8.88$). The number of therapy sessions received by this subsample of patients ranged from 20 sessions to a maximum of 364, with a mean of 74 ($SD = 65.2$). Forty-eight percent of patients received between 20 and 40 sessions, whereas the remaining 52% received more than 40 sessions.

As with the patient-rated alliance scores, the therapist-rated alliance scores for a given patient that counted at least three or more ratings (up to a maximum of four) were selected to model growth curves. The number of patients for whom at least three therapist-rated alliance scores had been obtained was 162. The therapists began rating the alliances about 1 year into the project, which explains why a lower number of alliance ratings was acquired from the therapists than from the patients.

Therapists. The therapist sample consisted of 70 psychotherapists (46 psychologists, 14 psychiatrists, eight physiotherapists specializing in Affect Consciousness psychotherapy (Monsen & Monsen, 1999), and two 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 ranged from one to 11 patients, with the average being almost five patients each. The majority in the sample (78.3%) reported a psychoanalytic/psychodynamic salient orientation, which is defined as a rating of 4 or more on a 5-point Likert scale, measuring the degree

to which therapists are influenced by various theoretical orientations from 1 (*not at all*) to 5 (*very much*), allowing for ratings of multiple orientations. A substantial portion of therapists in the sample also reported having a salient orientation in the humanistic (29.4%) and cognitive (28.7%) therapy models.

Measures

Dependent variable.

Working alliance. The short 12-item version of the WAI (Horvath & Greenberg, 1989; Tracey & Kokotovic, 1989), in both the patient-rated (WAI-P) and therapist-rated (WAI-T) versions, was used to assess the working alliance in this study. The WAI was constructed to measure the degree of collaboration between therapist and patient in terms of agreement of the Tasks and Goals of therapy and the quality of the emotional Bond between the two, in accordance with the three aspects of Bordin's (1979) model. In the WAI, respondents are asked to rate the degree to which they feel various statements describing the relationship and collaboration in the therapeutic work to be true on a 7-point Likert scale ranging from 1 (*never*) to 7 (*always*). The WAI has demonstrated good temporal stability, high internal consistency scores (Horvath, 1994), and high correlations with other alliance measures (Horvath, 1994; Horvath & Greenberg, 1989). In order to test the factor structure of the WAI, Tracey and Kokotovic (1989), using confirmatory factor analysis, showed that the best model fit for WAI responses is achieved for a hierarchical two-level factor structure with a higher order global alliance factor and three first-order factors (corresponding to Tasks, Goals, Bond). The existence of a general second-order alliance dimension has led to a common procedure of using an averaged sum score as the alliance index in several studies (Hersoug et al., 2009b; Stiles et al., 2004), including this one.

Patient control variable.

Interpersonal distress. The focus of this study was to investigate therapist predictors of alliance development, and we therefore wanted to control for caseload differences between therapists in their patients' overall levels of interpersonal distress, which is a variable known to be of relevance for alliance formation (Constantino & Smith-Hansen, 2008; Nissen-Lie et al., 2010). Interpersonal problems were assessed using the circumplex version of the IIP-64 (Horowitz, Alden, Wiggins, & Pincus, 2000). The IIP-64 contains eight subscales, each with eight items that reflect the octants of the interpersonal circumplex. There are two types of items: 39 items following the phrase "It is hard for me to . . ." and 25 items that describe "Things that you do too much." Each item was rated on a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*). The IIP-64 has demonstrated strong psychometric properties in terms of test-retest reliability, internal consistency, and construct validity (Horowitz et al., 2000), which also applies to the Norwegian version of the scale (Monsen, Havik, Eilertsen, & Hagtvet, 2006). A global interpersonal distress score was calculated from the total IIP-64 score assessed at baseline. This global

¹ Note that an overlap between clusters was possible.

measure is regarded as a reliable and valid measure of self-reported interpersonal distress (Gurtman & Balakrishnan, 1998).

Therapist measures.

The DPCCQ instrument. The therapist factors that were used as predictor variables in this study were collected using the DPCCQ (Orlinsky et al., 1999). The DPCCQ is a 20-page, comprehensive, structured survey questionnaire consisting of 370 items covering a wide range of therapists' experiences. It is divided into subsections measuring psychotherapists' professional training and experience, current and overall career development, current work experiences as a therapist, and personal characteristics. Most of the questions take the form of fixed responses on 4- to 6-point Likert-type scales.

Quality of therapists' personal lives. The questionnaire section tapping personal life experiences (*Psychotherapists' quality of life scale*) was used in this study. In this the following questions are asked:

1. How satisfying is your own life at present?
2. How stressful is your life at present?
3. How frequently do you experience a sense of being genuinely cared for and supported?
4. How frequently do you experience moments of unreserved joy?
5. How frequently do you freely express your private thoughts and feelings?
6. How frequently do you feel a satisfying sense of emotional intimacy and emotional rapport?
7. How frequently do you feel a heavy burden of responsibility, worry, or concern?
8. How frequently do you feel a sense of significant conflict, disappointment, or loss?

These items are rated on a 6-point Likert scale ranging from 0 (*never*) to 5 (*very frequently*). On the basis of the data available at the time ($N = 4,828$), Orlinsky and Rønnestad (2004) performed principal component analyses on these scales, yielding one positively loaded factor (Personal Satisfaction), which includes the

five positively loaded items listed above, and one negatively loaded factor (Personal Burdens), which includes the three negatively loaded items listed above. These two-factor scales were used as predictors in this study. Alpha scores of the factors were calculated for the current therapist sample (Personal Satisfaction = .75 and Personal Burdens = .63). Compared with the large-scale international study conducted by Orlinsky and Rønnestad (2004), the two quality-of-life factors from the present sample show comparable descriptive statistics, but slightly lower alpha scores. See Table 1 for more information on Personal Satisfaction (PS) and Personal Burdens (PB) in this sample.

In their analyses, Orlinsky and Rønnestad (2004) found that among the professional characteristics that most strongly correlated with therapist quality of life were the therapists' work involvement styles (see Orlinsky & Rønnestad, 2005). The model of "work involvement" is composed of two broad dimensions: "Healing involvement" and "Stressful involvement," encompassing a number of subdimensions each. Healing involvement is composed of the following first-order factors from various DPCCQ subscales: "Invested relational agency"; "Affirming" and "Accommodating" interpersonal styles; in-session feelings of "Flow," use of "Constructive coping," and possession of "Basic relational skills." Stressful involvement, however, is composed of the following factors: Frequent difficulties; in-session feelings of "Anxiety" and "Boredom," and unconstructive coping called "Avoiding therapeutic engagement" (Orlinsky & Rønnestad, 2005). In Orlinsky and Rønnestad's (2004) large-scale study of almost 5,000 therapists, PS was most strongly related to the therapists' experience of work as a Healing involvement ($r = .42$), and PB was clearly related to Stressful involvement ($r = .26$). With regard to the cause and effect in this interplay, the authors argue that both mechanisms may account for the correlations. For example, concerning the relationship between PB and Stressful involvement, therapists may experience greater personal distress when their therapeutic work is stressful, as well as being more likely to experience their therapeutic work as stressful when they are burdened in their personal lives (Orlinsky & Rønnestad, 2004). PS also correlated with the therapist's sense of work setting support and satisfaction ($r = .30$), currently experienced growth ($r = .30$), satisfaction with therapeutic work ($r = .29$), and professional autonomy ($r = .22$). However, therapists who were currently burdened were somewhat more likely to manifest currently experienced depletion in their

Table 1
Descriptive Statistics for Personal Satisfaction and Personal Burdens

Factor/items	N	M	SD	Min	Max	% "high" ^a	α
Personal Satisfaction	67	3.73	.59	2.20	5.00		.75
How satisfying is your own life at present?	68	3.62	.75	.00	5.00	64.7	
How frequently do you . . . Experience a sense of being genuinely cared for?	70	3.81	.82	2.00	5.00	70.0	
Feel a satisfying sense of intimacy and emotional rapport?	69	3.83	.92	2.00	5.00	65.2	
Experience moments of unreserved joy?	69	3.59	.88	1.00	5.00	57.9	
Freely express your private thoughts and feelings?	69	3.72	.84	2.00	5.00	65.2	
Personal Burdens	69	2.39	.83	.33	4.67		.63
How stressful is your life at present?	69	3.00	1.20	.00	5.00	34.8	
How frequently do you . . . Feel a heavy burden of responsibility, worry or concern?	70	2.45	1.10	.00	5.00	12.9	
Feel a sense of significant conflict, disappointment or loss?	70	1.69	.99	.00	4.00	4.3	

^a "high" = 4 or 5 on a 0–5 scale.

professional work ($r = .16$) and to be dissatisfied with the work as a therapist ($r = .15$).

Despite these preliminary, yet unpublished findings, the analyses conducted in the present study are exploratory, given that these factors have not previously been investigated in relation to psychotherapy process or outcome.

Procedure

The patients in the project were assessed by trained coordinators (clinical psychologists or psychiatrists) at the clinics. The diagnostic assessments were conducted using Structured Clinical Inventory of the *DSM-IV* (SCID-I and SCID-II) interviews (First, Spitzer, Gibbon, Williams, & Benjamin, 1994; Spitzer, Gibbon, Skodol, Williams, & First, 1994), based on the *DSM-IV* criteria (American Psychiatric Association, 1994). Observer-rated global functioning was evaluated using the GAF (Endicott et al., 1976). The patients also completed a number of self-report questionnaires measuring symptoms, interpersonal problems, self-image, and so on, at pretreatment; at intervals throughout the treatment process; at the end of treatment; and at 6, 12, and 24 months after treatment.

The participating therapists were staff members at the clinics involved, who had volunteered to take part in this longitudinal study. The patients were assigned to the therapists as they were referred by the local coordinator, based on their availability and after being screened for exclusion criteria. Participation in the NMSPOP was based on informed and signed consent. The project was approved by the Regional Committee for Medical Ethics in Eastern Norway.

The therapists completed the DPCCQ self-report survey a maximum of six times during the project period at 1-year intervals to enable an investigation of therapist development. As in the other studies on early working alliance (Nissen-Lie et al., 2010) and outcome (Nissen-Lie et al., 2013), the therapists' responses to the second administration of the DPCCQ instrument was used as the basis for analyses on therapist factors and alliance quality, because several scale items were lacking in the first DPCCQ administration in this project.

Evaluations of the working alliance were collected at the end of the third therapy session, then after Sessions 12, 20, and every 20th consecutive session thereafter (40, 60, and so on). In this investigation, WAI ratings up to Session 40 are included, so the longitudinal variables are based on a maximum of four ratings. See Table 2 for the descriptive WAI-P and WAI-T at each time point.

Table 2
Descriptives of Working Alliance Inventory Scores Rated by Patients (WAI-P) and Therapists (WAI-T)

Measure	Session	<i>N</i>	<i>M</i>	<i>SD</i>
WAI-P	3	227	5.10	1.05
	12	222	5.26	.91
	20	222	5.35	.97
	40	148	5.43	.92
WAI-T	3	152	4.92	.81
	12	156	5.12	.77
	20	153	5.29	.70
	40	92	5.32	.67
	60	52	5.35	.71
	80	42	5.28	.74

Data Analyses

Multilevel modeling. Multilevel growth curve analyses were used to examine therapist effects in WAI-P and WAI-T and to assess whether or not the therapist variables were associated with the levels of (intercept) and development in (slope) WAI-P and WAI-T. The choice of multilevel modeling (MLM) as the statistical/methodological procedure was justified due to the hierarchical structure of the data and the dependence caused by nesting. Repeated measurement occasions of WAI-P and WAI-T (Level 1) were nested within patients (Level 2), who in turn were nested within therapists (Level 3). The assumption of independent observations underlying standard statistical procedures, such as repeated measures analysis of covariance, was thus violated (Lutz, Leon, Martinovich, Lyons, & Stiles, 2007; Singer & Willett, 2003; Tasca & Gallop, 2009). MLM has the further advantage of separating and explaining variance at different levels and is robust in allowing for missing observations or unequally distributed measurements available at each level (Hox, 2002, 2010; Maas & Hox, 2005). This is particularly important in this study, because the number of patients nested within each therapist varied, as did the number of alliance evaluations per patient or per therapist.

MLM growth curve procedure. The MLM growth curve procedure began by modeling an unconditional means model (without any predictor) in order to calculate the amount of therapist variability in WAI-P and WAI-T intercepts. In this three-level model, the therapist variability was calculated as the intraclass correlation (ρ):

$$\rho = \sigma_{\text{ther}}^2 / (\sigma_{\text{ther}}^2 + \sigma_{\text{patient}}^2 + \sigma^2 e),$$

where σ_{ther}^2 refers to the residual therapist (Level 3) variance in the fixed intercepts (means), $\sigma_{\text{patient}}^2$ refers to the residual patient (Level 2) variance, and $\sigma^2 e$ refers to the total within-person residual (i.e., the variance of repeated measurements at Level 1). Thus, ρ refers to the proportion of therapist variation in the longitudinal alliance measures relative to the proportion of variation explained by patients and by time, thereby taking all three levels into account.

In the next unconditional growth model, time (modeled as a fixed slope across the four measurements) was included. This time variable was transformed into its natural logarithm (log time) in order to achieve a better fit of the model to the data compared with a linear model. After entering log time as a predictor at Level 1, the patient control variable denoting global interpersonal distress before treatment (IIP-64 pre) was entered at Level 2, followed by the therapist predictors (at Level 3). The therapist factors were tested in two different models (one for WAI-P and one for WAI-T) exploring their effect on the level (intercept) and the rate of change (slope) of the working alliance.

The focus of this study was on the relation of the therapist factors to alliance levels and growth; thus, only the fixed effects (the patients' average slopes within therapists), and not random effects, were modeled. In the multilevel growth modeling procedure, models with fixed effect coefficients were run, and the random coefficient model included only the intercept. The patient control variable (i.e., IIP-64 pre), time, and the therapist predictors were grand mean centered, as recommended in the literature (Hox, 2002; Singer, 1998). This was done in order to reduce the problem of multicollinearity and to aid the interpretation of the findings. The maximum likelihood estimation method was used in the

procedures, as recommended by Hox (2002), when modeling fixed effects with relatively large samples (= 70 therapists) (Maas & Hox, 2005). The software linear mixed models (IBM SPSS version 20, 2013) was used to conduct the MLM growth curve analyses.

Results

Patient-Rated Alliance (WAI-P): Multilevel Growth Curve Modeling

Model 1: Unconditional means model. The therapist intraclass correlation (ρ) of WAI-P across the four measurements was calculated from the unconditional means model:

$$\rho = .1703 / (.1703 + .4954 + .2700) = 0.182.$$

Thus, 18.2% of the variance in the longitudinal patient-rated alliance measure could be ascribed to differences between therapists.

Model 2: Unconditional growth model. The unconditional growth curve model included log time and patients' baseline IIP-64 global. This model yielded a significant and positive growth coefficient ($B = .65, p < .001$) and a negative influence of the IIP-64 pre on WAI-P intercept ($B = -.36, p < .001$).²

Model 3: Conditional growth curve models with PS and PB. The model simultaneously examining the effect of PS and PB on patient-rated alliance indicates that PS did not affect the WAI-P group intercept or slope ($B = .08, p > .05; B = .06, p > .05$). Although the effect of PB on the WAI-P intercept was close to significant ($B = -.22, p = .06$), a highly significant, negative impact of PB on the rate of change was demonstrated ($B = -.34, p < .01$).

Therapist-Rated Alliance (WAI-T): Multilevel Growth Curve Modeling

Model 1: Unconditional means model. An unconditional means model of WAI-T was fitted, providing a division of the variance related to measurement occasions (Level 1), patients (Level 2), and therapists (Level 3), yielding the following therapist intraclass correlation:

$$\rho = .1361 / (.1361 + .2418 + .1845) = 0.2420.$$

Thus, 24.2% of the variance in the longitudinal WAI-T could be attributed to differences between the therapists.

Model 2: Unconditional growth models (correcting for patient IIP-64 global). In the unconditional growth model, the centered log time was included. The patient global interpersonal disturbance (IIP-64 pre) was included to control for the severity of interpersonal distress between therapists, but it failed to demonstrate a significant effect on the WAI-T level ($B = -.15, p > .05$). This implies that the therapists were not influenced by their patients' pretreatment interpersonal distress when evaluating the alliance.

Model 3: Conditional growth curve models with PS and PB. The model sets investigating therapist private life quality and WAI-T revealed a nonsignificant effect of PS on the alliance intercept ($B = .24, p > .05$). However, PS had a significant, positive effect on alliance growth ($B = .39, p < .05$). PB was

Table 3
Results of MLM Growth Curve Analyses: Therapists' Reports of Their Personal Burdens and Personal Satisfactions as Predictors of Patient-Rated Alliance (WAI-P) and Therapist-Rated Alliance (WAI-T)

Parameter	WAI-P	WAI-T
	Estimate (SE)	Estimate (SE)
Intercept	5.36*** (.08)	5.19*** (.08)
Slope	.65*** (.09)	.87*** (.09)
Treatment length	-.0008 (.0009)	-.0008 (.00009)
IIP-64 pre	-.36*** (.11)	-.12 (.10)
Personal Burdens	-.10 (.11)	-.003 (.10)
Personal Burdens × Slope	-.34** (.13)	.15 (.13)
Personal Satisfactions	.08 (.15)	.22 (.11)
Personal Satisfaction × Slope	.06 (.13)	.39** (.15)

Note. MLM = multilevel modeling; WAI = Working Alliance Inventory; IIP-64 = 64-item Inventory of Interpersonal Problems.
** $p \leq .01$. *** $p \leq .001$.

unrelated to both the WAI-T intercept ($B = -.0003, p > .05$) and slope ($B = .15, p > .05$).

See Table 3 for reports of the statistics of the analyses predicting WAI-P and WAI-T. See also Figures 1 and 2, which illustrate the main findings. Figure 1 depicts the growth in WAI-P for patients treated by therapists with high (above the mean) and low (below the mean) scores on PB, whereas Figure 2 shows the difference in therapist-rated alliance depending on the level of PS (high/low) of the therapists.

Due to the robust relationship between therapist quality of life and alliance development found in this study, we decided to assess the temporal stability of PS and PB through the 5-year measurement period the DPCCQ had been administered to the therapists in the NMSPOP. We used MLM growth curve analyses in order to account for the dependency in the data (with multiple measurements of quality of life nested within therapists), with only time as a predictor. These analyses show that neither the PB rate of change (slope) nor the PS slope changed significantly in the two factors throughout the 5-year measurement period ($B_{PBslope} = .17, p > .05$; and $B_{PSslope} = -.11, p > .05$). These findings indicate that both PS and PS are fairly stable constructs. See Figure 3.

Moreover, we conducted moderator analyses in which we included the interaction term PB × PS in the MLM equation predicting both the patient-rated and therapist-rated alliances to examine whether or not the combination of PS and PB had an effect on either WAI-P or WAI-T. This interaction term was not significant for WAI-P or WAI-T, indicating that the effect of one did not depend on the level of the other in predicting the working alliance scores. Also, we controlled for the number of treatment sessions each patient had received, and treatment time did not affect alliance levels or growth, nor did it yield a significant interaction with PS or PB on alliance. Finally, we investigated the interactions between patients' IIP-64 global at baseline and both PS and PB, but these analyses show that patients' interpersonal distress did not affect the relationship between the therapist factors and the working alliance.

² Note that the intercept in this model represents the alliance starting point at the end of Session 3.

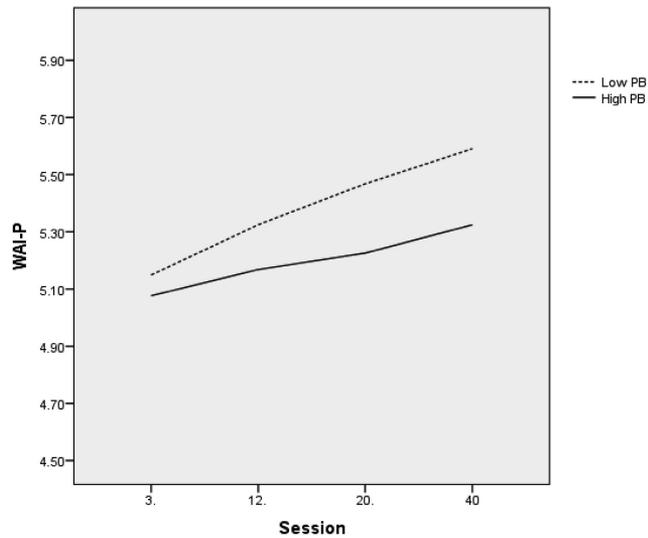


Figure 1. Development in patient-rated alliance for patients treated with therapists high (above the mean) or low (below the mean) on Personal Burdens (PB). WAI-P = Working Alliance Inventory patient-rated version.

Discussion

The findings from this study support previous investigations demonstrating that therapists differ considerably in their ability to foster a working alliance with their patients (Crits-Christoph et al., 2009; Dinger et al., 2008; Marcus et al., 2009; Nissen-Lie et al., 2010; Owen et al., 2011). The level of therapist variability in the longitudinal alliance scores provided by patients and therapists was relatively high (18% for WAI-P and 24% for WAI-T) and

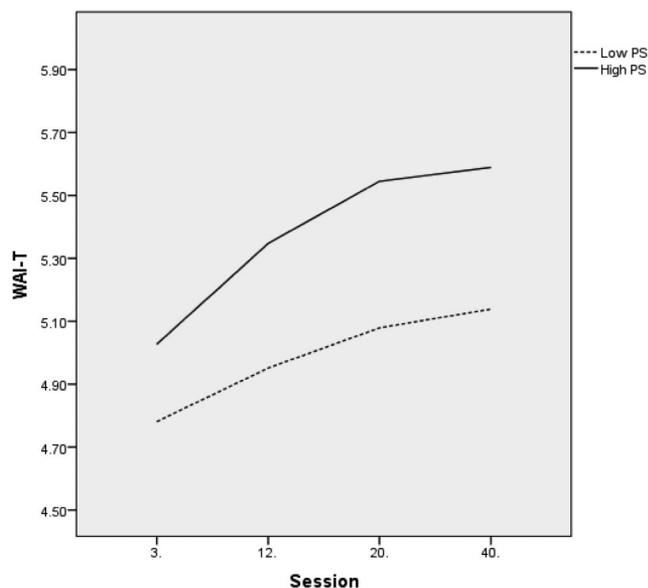


Figure 2. Development in therapist-rated alliance for therapists high (above the mean) or low (below the mean) on Personal Satisfaction (PS). WAI-T = Working Alliance Inventory therapist-rated version.

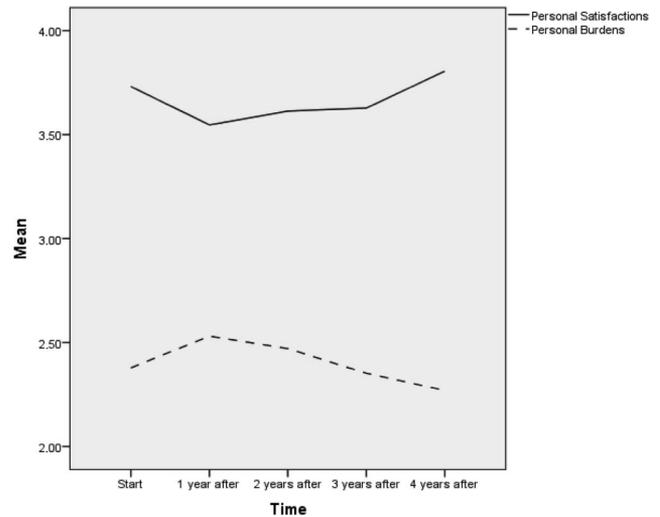


Figure 3. Nonsignificant change in Personal Satisfaction and Personal Burdens throughout the 5-year measurement period of the Quality of Personal Life Scale.

higher when the alliance was rated by the therapists compared with by the patients. Such effects justify an exploration of what aspects of the therapist that may explain these therapist differences in alliance scores. Examining therapists' reports of the quality of their ongoing personal lives and private relationships as predictors of the working alliance yielded that these experiences are relevant both for their own and their patients' evaluations of the working alliance over time. We may infer from this finding that psychotherapists' quality of life influences the way in which they relate to their patients in the therapy sessions.

However, the rater perspective, that is, whether the alliance was rated by patients or by therapists, seems to distinguish the nature of the relationship between therapists' quality of life and the working alliance. This divergence is discussed below. The therapists' quality of life did not change significantly during the course of the 5-year period over which it was measured in this project, which indeed suggests that these constructs are relatively stable traits that may be related to both personality and coping styles rather than to states that fluctuate according to the vicissitudes of one's personal life. This knowledge enables us to better understand how therapists influence the therapy process.

The idea that personal life quality influences therapists' available emotional reserves and their capacity to attune to patients who suffer from various forms of psychological distress, and therefore often present with challenging interpersonal behaviors, has been suggested by psychotherapy authors since the beginning of psychotherapy research (Rogers, 1961; Strupp, 1958). The findings of this study support this idea, as well as previous empirical studies, such as that of Dunkle and Friedlander (1996), which revealed that therapists' perception of social support and quality of their private life relationships were positively associated with their patients' alliance evaluations, whereas professional factors were not. Hersoug et al. (2009b) noted that when therapists described themselves as somewhat distant and detached in their private relationships, their patients rated the alliance as weaker than that with therapists who described themselves as less distant or cold in their

personal lives. Such findings suggest that therapists report their private interpersonal styles in honest and reliable ways and that they act at least to some extent in correspondence with their self-assessed interpersonal styles in the therapy room. This in turn influences patients' perceptions of the emotional bond and collaborative climate in therapy.

This study has exposed some notable divergences in the prediction of alliance development, depending on the rater's perspective. We argue that these discrepancies contain information about the working mechanisms of psychotherapy, and, if replicated, they may have important implications for both psychotherapy theory and practice.

The first divergence between patients' and therapists' alliance evaluations shows that whereas the patient-rated alliance was influenced by the level of interpersonal distress in patients prior to treatment, this was not replicated for the therapist-rated alliance. We know from previous studies that increased interpersonal distress in patients often reflects a relational vulnerability that contributes to increased difficulty in forming a trusting and collaborative relationship in treatment (e.g., Constantino & Smith-Hansen, 2008; Hersoug, Høglend, Havik, von der Lippe, & Monsen 2009a; Nissen-Lie et al., 2010). One possible explanation of why this variable did not influence the therapists in our study may be that, as professionals, they adjusted their alliance expectations in accordance with their patients' interpersonal disturbances, so that when working with a more vulnerable patient, they expected a lower alliance and rated it according to those expectations (Horvath, 2000).

Another discrepancy relates to how the two therapist factors denoting therapists' satisfactions and distress relate to alliance development, when the alliance was rated by patients compared with therapists. Whereas therapists' reports of personal conflicts and burdens had little effect on their own alliance ratings, these experiences were strongly and inversely related to alliance development over time when the alliance was observed by their patients. However, therapists' reports of a satisfying private life, with elements of unreserved joy, satisfying intimacy, and emotional support, contributed to higher alliance ratings from their own vantage point, but this factor had little bearing on the patient evaluations. How can we understand this? The following discussion identifies three issues that may help to explain this discrepancy: (a) social desirability issues, (b) salience of negative emotionality, and (c) therapists' countertransference.

Social Desirability

One reason why the therapists' own alliance ratings were uninfluenced by their personal burdens might be that therapists are inclined to think that such experiences do not constitute a noticeable hindrance to their working alliances. The possible spillover of one's personal burdens into the daily therapeutic work might be something that therapists find socially undesirable and hard to accept. Conversely, when therapists report higher private life satisfaction, their own alliance evaluations increase, but their patients' evaluations remain unaffected. When the therapists themselves feel more satisfied or fulfilled, they seem to become predisposed to perceive the alliances with their patients in a more positive light, but their ability to form better alliances may not actually improve.

Salience of Negative Emotionality

The findings also suggest that, when the alliance is rated by the patients, the most important sources of influence from the therapists' quality of life are those that are negative in valence, rather than positive. We may infer that therapists' negative emotional states are more salient to patients. This is in line with findings of other studies that demonstrate the particularly detrimental effects of therapists' negative emotionality (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010; Nissen-Lie et al., 2010; Wolff & Hayes, 2009). Perhaps due to their vulnerability that stems from suffering from mental health problems, and because of the power imbalance in the patient-therapist relationship, patients may have a special "radar" or increased sensitivity toward their therapists' negative reactions. Even subtle signs of disinterest, rejection, aggression, or defensive behaviors may result from increased burdens in the therapist's personal life, and this may lead to deterioration in the alliance.

Therapist's Countertransference

The idea that therapists' personal and emotional lives affect therapy is far from new; Freud (1910/1959) noticed that his proposed ideal of neutrality was difficult to achieve and that both he and his analyst colleagues were sometimes hindered in their work by their own emotions, complexes, and resistances. He coined the term "countertransference" to define these feelings and recommended that analysts overcome them or seek further psychoanalysis in order to minimize the detrimental effects on patients' growth in treatment. Although Freud himself recognized the challenges inherent in dealing with countertransference, he did not write extensively about it, and it was not until 40 years after the term was coined that theorists began to explore the concept further (Heinmann, 1950; Little, 1951).

Today, how to define, understand, and use one's countertransference remains one of the core discussions in psychoanalytic writings. Many theorists agree that countertransference can be conceptualized as the therapists' reactions that are rooted in unresolved personal issues, as well as being the key to understanding the patients' repressed, unconscious impulses or transference phenomena (Gabbard, 2001). Countertransference feelings that are rooted in the therapists' own unresolved personal issues may coincide with feeling burdened in their personal lives. This study shows that therapists who felt more burdened in their personal lives had alliances that did not improve as much as those of therapists who felt relatively unburdened. This may, in part, reflect the harmful effects of the therapists' countertransference and, as such, would support the findings of Ligiéro and Gelso (2002), who observed a negative correlation between the alliance and countertransference behavior, defined as either underinvolvement or overinvolvement in therapy sessions. Furthermore, research suggests that therapists who are better able to manage negative countertransference seem to be able to form a better working alliance and to have deeper sessions with their patients, compared with those with a greater tendency to act out their countertransference feelings during sessions (Gelso, Latts, Gomez, & Fassinger, 2002; Hayes, Riker, & Ingram, 1997).

However, one limitation to introducing countertransference as a relevant concept in understanding the present findings is that, even when rooted in the therapists' own unresolved issues, countertrans-

ference is often considered to be feelings elicited as a response to patients' (transferential) material. Therefore, the term *chronic countertransference* (Reich, 1951) may be more appropriate. Chronic countertransference is defined as the therapists' habitual disturbances that have become part of their personality structure and are present independent of the client material brought forth (Gelso & Hayes, 2002). Because we know that the PB factor probably reflects a fairly stable construct (at least over the span of 5 years), the factor may relate to therapists' more stable therapeutic "blind spots" or defensive reactions as a form of chronic countertransference. This view is supported by Schröder et al. (2009), who identify a positive association between stress in therapists' lives and difficulties in psychotherapy practices and that increased stress in one's personal life is associated with the tendency to use avoidant coping. These mechanisms are presumably unconscious, or beyond the awareness of the therapists, but they are nonetheless noticeable for the patients.

To summarize, it seems that when therapists are less burdened in their personal lives, they become more capable of dealing with their patients' needs and of conducting therapy in a way that enables them to establish strong alliances that improve over time and that presumably can be repaired in case of alliance ruptures (Safran & Muran, 2000).

Methodological Limitations

In this study, we investigated alliance ratings obtained from both patients and therapists, but due to the fact the therapists started to evaluate the alliance 1 year into the NMSPOP project period, available therapist-rated alliance scores were considerably fewer ($n = 162$) compared with the patient-rated alliance scores ($n = 227$), which may have led to some distortions in the findings. However, patient-rated and therapist-rated alliance scores were investigated separately in the multilevel regression analyses, so the dyadic correlation coefficients between WAI-P and WAI-T scores were not used in the models. Selecting patients who had at least three alliance ratings of a maximum of four (i.e., WAI ratings after Sessions 3, 12, 20, and 40) in order to properly model growth curves (Hox, 2010) may have excluded cases of premature termination or other forms of treatment failure, and influenced the associations found in the study. Problems concerning generalizability of the findings with respect to (a) therapists without a psychodynamic salient theoretical orientation, (b) therapists in other countries, or (c) therapies conducted more recently should also be mentioned. The question of whether therapists' quality of life, as assessed by the PS and PB factor scales, is better conceptualized as states or traits is also warranted, because one-time evaluations of these scales were used as predictors in the study (assuming to some extent they are stable traits). The multilevel growth analyses of the PS and PB factors over the 5-year measurement period revealed that they did not change significantly. This indicates a certain temporal stability in these factors. Nevertheless, a 5-year period is short in a career perspective. Although adverse and even traumatic experiences in therapists' adult personal life may exert a temporary, negative impact on professional functioning, lessons from interviews with senior therapists suggest that such experiences may in fact have a positive effect on different aspects of professional functioning in the longer run if they are processed and reflected upon (Rønnestad & Skovholt, 2001).

Concluding Remarks

The findings of this study call for more research to resolve some important issues. We believe that the nature of the relationship between therapists' quality of life and the working alliance is most likely influenced by possible moderating factors such as therapists' countertransference management ability (Gelso & Hayes, 2002, 2007), positive experiences of personal therapy or ongoing clinical supervision (Orlinsky, Norcross, Rønnestad, & Wiseman, 2005), as well as an advanced self-awareness or self-reflective capacity (Rønnestad & Skovholt, 2012; Skovholt & Jennings, 2004). We are curious to explore these possibilities in future studies.

Ultimately, the findings indicate that patients may be particularly sensitive to their therapists' private life experiences of distress, which are presumably communicated through the therapists' in-session behaviors, whereas the therapists' judgments of alliance quality are in a sense biased by their own sense of personal well-being. Although they are professionals, it is difficult for therapists to leave their personal life experiences behind when in the therapy room. In essence, the findings of this study support a two-subject view of psychotherapy in which both participants interpret and influence their mutual exchange.

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