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THERAPIST SELF-DOUBT WHEN FACING SEVERE PSYCHOPATHOLOGY IN  
ADOLESCENT MALES

An Abstract of a Thesis  
Submitted  
in Partial Fulfillment  
of the Requirements for the Degree  
Master of Arts

Zachary Mark Meehan  
University of Northern Iowa  
May 2019

## ABSTRACT

Achieving expertise in psychotherapy is a complex task, fraught with obstacles that impede progress (e.g., cognitive and information processing, accuracy of self-appraisals; Tracey, Wampold, Lichtenberg, & Goodyear, 2014). Contrary to popular opinion, years of experience does not make for an expert therapist. Research indicates that more seasoned therapists are not necessarily more effective than less seasoned therapists in terms of client outcomes. Expertise requires not only time, but also an intention to improve; and the use of appropriate feedback systems. Certain therapist characteristics can reliably predict therapy process and outcome. For example, the degree to which therapists feel uncertain regarding their ability to help clients, known as self-doubt, is a particularly strong predictor of client outcomes (Nissen-Lie, Monsen, Ulleberg, & Rønnestad, 2013). Currently, little is known about therapists' self-doubt regarding clients' different presenting problems. There is qualitative evidence that therapists experience the greatest self-doubt in response to clients who are, subjectively, described as high-stakes, unmotivated, violent, aggressive, suicidal, and intensely emotional (Thériault & Gazzola, 2010). Among disorders that manifest these characteristics, conduct disorder (CD) in adolescence is the most representative. This is the first, known study which examined the relation between client characteristics and the expression of self-doubt among therapist trainees in the United States. Participants in the current study read and responded to four vignettes portraying scenarios of adolescent boys with mental illness, in a within-subjects design. Self-doubt was assessed after each vignette using a measure constructed and validated for developing therapists (Orlinsky & Rønnestad,

2005). Ancillary measures assessed participants' interpersonal reactivity (i.e., perspective taking, empathic concern) as well as their sense of self-efficacy in various counseling behaviors (i.e., session management, counseling challenges). Therapist trainees expressed greatest PSD when working with adolescent males who exhibit CD-Severe, followed by obsessive-compulsive disorder (OCD) and CD-Mild equally, and finally social anxiety disorder (SAD). Overall, clients with externalizing disorders elicit the greatest PSD among therapist trainees. This information may provide evidence for self-doubt as a target in therapist feedback systems in the quest to develop expertise in therapy.

*Keywords: Professional Self-Doubt, Conduct Disorder, Expertise, Feedback*

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This Study by: Zachary Mark Meehan

Entitled: Therapist Self-Doubt When Facing Severe Psychopathology in Adolescent Males has been approved as meeting the thesis requirement for the

Degree of

_____	_____
Date	Dr. Elizabeth Lefler, Chair, Thesis Committee
_____	_____
Date	Dr. Robert Hitlan, Thesis Committee Member
_____	_____
Date	Dr. Seth Brown, Thesis Committee Member
_____	_____
Date	Dr. Jennifer Waldron, Dean, Graduate College

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## CHAPTER 1

### INTRODUCTION

Therapists visit with clients who present with a variety of disorders, along with accompanying symptomatology and etiology that are unique to their situation. It can be challenging for therapists to reliably and consistently produce positive outcomes among their clients. Considering these challenges, formal feedback systems may address components of the therapy process in order to better ensure positive client outcomes as well as continual therapist improvement. One potential component of a formal feedback system may be professional self-doubt, or the level of uncertainty a therapist has in their ability to help a client. There is, however, little research describing (a) the conditions in which self-doubt varies by unique client characteristics, (b) the therapist characteristics related to self-doubt, and (c) self-doubts' relation to other related constructs (e.g., self-efficacy). The primary purpose of this study is to elucidate the conditions of variability to support the usage of self-doubt in formal feedback systems for therapists. The secondary purpose of this study is to better understand self-doubt's relation to therapist characteristics as well as similar constructs.

#### Expertise in Therapy

There is no singular value that can be used to quantify expertise in therapy. Operationalizations of the term are often flawed. Some definitions of expertise involve therapists' reputation, performance in diagnostics or treatment, and even their typical client's outcomes. None of these definitions perform well under scrutiny, however (Tracey, Wampold, Lichtenberg, & Goodyear, 2014). The most commonly used and best-

supported definition was provided by Shanteau (1992), who stated that expertise in therapy involves an increase in performance quality over time through gainful experience. It is because this definition emphasizes experience gained through intentionality that many scholars have accepted its use (Tracey et al., 2014).

The relation of expertise to experience is, unsurprisingly, more complex than as a function of time. More seasoned therapists are not necessarily more effective in improving client outcomes than their less seasoned counterparts. A large naturalistic study of approximately 6,000 clients seen by nearly 600 therapists illustrated this claim (Wampold & Brown, 2005). Neither therapists' age, nor gender, nor years of experience, nor professional degree were significantly related to client outcomes (Wampold & Brown, 2005). Results such as these are not unique, as others corroborated the evidence that years of experience and level of training are poor predictors of client outcomes (e.g., Budge et al., 2013; Laska, Smith, Wislocki, & Wampold, 2013). Time, and more specifically experience over time, is only one of several opportunities by which therapists may improve the quality of their performance. For instance, reliable supervision and feedback provides likely the best opportunity for continual improvement of therapist performance (Norcross, 2011; Rønnestad, Orlinsky, Schroder, Skovholt, & Willutzki, 2018). However, there are numerous obstacles which prevent or hinder progress in this regard.

### The Obstacles to Expertise

Tracey and colleagues (2014) provide a review of factors that are considered obstacles to achieving expertise in therapy. The factors include cognitive and information

processing, therapists' engagement in deliberate practice, the accuracy of self-assessment of performance, and availability of reliable feedback. Among these factors, self-assessment of performance—the self-appraisal of strengths and weaknesses—has received considerable attention in recent years (e.g., Nissen-Lie et al., 2013; Nissen-Lie et al., 2017; Wampold, 2015). The accuracy of these assessments depends, in part, upon two factors: the work environment and the method of appraisal.

The ability to accurately assess performance is likely due to the predictability of the work environment (Kahneman & Klein, 2009). The reliability of expert judgement, in other words, depends on the regularity of aspects within an individual's setting. Regularity of the environment undoubtedly varies by field (e.g., business vs. therapy). Fields with greater predictability are termed *high validity environments*. These environments are relatively stable and routine in terms of the daily responsibilities, tasks, and expert knowledge. For instance, many areas require standard skills and training which prepare individuals to operate under predictable working conditions (e.g., fire-fighting, aspects of nursing). That is not to say fire-fighting or nursing are simple or easy jobs. Rather, situations that individual's experience within these positions likely have documented precedent, with available solutions that are routine and well-supported (Kahneman & Klein, 2009). People who hold positions such as fire-fighting or nursing, therefore, are better equipped to accurately self-assess their own effectiveness without additional help (e.g., from supervision, from structured tools).

Alternatively, some environments are less predictable; subject to variation that makes expert judgement less reliable. Mental health diagnosis and long-term treatment

recommendations are examples in which individuals may find unpredictable conditions (Macdonald & Mellor-Clark, 2015). Less predictable fields are termed *low validity environments*. A therapist may see two people who receive the same diagnosis. This diagnosis may manifest across the individuals as separate symptomatology and may stem from differing etiologies. For example, two clients may experience depression with different causes (e.g., trauma vs. significant life changes) and express different symptoms (e.g., suicidal ideation vs. no suicidal ideation). As such, clients' presentations of symptoms are diverse, with multifactorial determinants; thus, therapists are forced to adapt to multiple variations during treatment. The inconsistency creates difficulty in anticipating outcomes from subjective predictions.

Expert judgements in high validity environments are often reliable (Kahneman & Klein, 2009), whereas they are less reliable in low validity environments (Kahneman, 2011). Despite their clinical skills and ability, it is incredibly difficult—without help—to accurately self-assess performance and predict outcomes in low validity environments. Stated clearly, self-assessment may include either unstructured (e.g., using introspection; Wittman, Weiss, & Metzmacher, 2012) or structured methods of appraisal (e.g., using scales; Lent, Hill, & Hoffman, 2003; Orlinsky & Rønnestad, 2005). The difficulty of therapists in self-assessing their own performance illustrates the need for (a) reliable and predictive targets for self-appraisal and (b) accurate methods of self-appraisal using structured methods.

Unfortunately, the ability to self-assess performance can be poor, if unstructured, as the belief in one's ability to perform well is not a reliable predictor of actual



performance. This conclusion is consistent among many fields (Dunning, Heath, & Suls, 2004). Compared to objective assessments, people in various fields tend to overestimate both concurrent performance as well as the outcomes they produce. This tendency has been coined the *above average effect*, in which most individuals believe themselves to be within the minority of high performers (Alicke, Klotz, Breitenbecher, Yurak, & Vredenburg, 1995; Macdonald & Mellor-Clark, 2015). Survey research asking people to attempt to provide unbiased self-assessments revealed that most people rate themselves above the mean. To illustrate, medical students' overestimate their clinical skills compared to more objective assessments (Woolliscroft, Tenhaken, Smith, & Calhoun, 1993). Self-report questionnaires of clinical performance at the beginning and end of an internal medicine internship correlated poorly with third party observations at both time points. Medical students overestimated their ability in several clinical settings (e.g., diagnosis, treatment recommendations; Woolliscroft et al., 1993). Likewise, when examining therapists, researchers asked participants about their therapy skills as well as performance (i.e., outcomes) relative to their colleagues (Walfish, McAlister, O'Donnell, & Lambert, 2012). Of the 129 therapists who responded, all believed themselves to be above average, and approximately one-quarter believed themselves to be in the top 10%. Self-assessment of performance is subject to internal biases (e.g., confirmatory bias) that distort one's views.

In addition to the inaccuracy of these self-assessments, the confidence one has in them increases over time (Gill, Swann, & Silvera, 1998). Thus, despite lacking evidence of actual improvement, people tend to believe they are improving (Tracey et al., 2014).

Therapists' predictions of client outcomes and eventual outcomes are poorly related (Witteman et al., 2012). For example, a therapist may predict that a client will utilize greater interpersonal skills outside of the therapy context when they do not. Multiple studies comparing novice therapists, those within the first few years of practice, to those with many years of experience fail to find significant differences in the ability to predict client outcomes (Spengler et al., 2009; Witteman & Van den Bercken, 2007). Because therapists assume that their ability improves over time, they may be less likely to engage in active improvement practices (Pintrich, 2003). To ensure more reliable predictions, therapists and supervisors should rely on more guided, structured assessments as evidence.

Given that the accuracy of self-assessments is flawed when they are unguided (Walfish et al., 2012), there is a necessity for more valid systems of appraisal. Unguided introspection, to reiterate, appears to poorly predict client outcomes (Woolliscroft et al., 1993). Recent investigations suggest the possibility that self-assessment can be accurate, but only under certain conditions (e.g., when maintaining healthy self-criticism; Nissen-Lie et al., 2017). Because self-assessments are potentially viable options for understanding performance in therapy, as seen by therapy process and client outcomes, they may provide targets for feedback in the effort to improve performance (Tracey et al., 2014; Macdonald & Mellor-Clark, 2015). The focus then changes from whether self-assessments can be accurate, to which structured self-assessments provide pertinent and predictive information.

Multiple measures exist whereby therapists may practice self-appraisals. Two commonly referenced constructs include self-efficacy and self-doubt. Self-efficacy refers to the belief in one's ability to successfully use therapy-related behaviors (e.g., keeping session topics on track, interacting with the client at a deep level). Measures of therapist self-efficacy are commonly used tools of self-assessment for developing therapists (Lent et al., 2003). Therapist self-efficacy is often considered when training therapists to understand their own growth and maturation (Hill, Sullivan, Knox, & Schlosser, 2007). Therapist self-doubt, or the lack of belief in one's ability to successfully treat clients, is similarly used within the domain of developing therapists (Orlinsky & Rønnestad, 2005). Despite being conceptually related concepts, there is disproportionately more research on therapist self-efficacy (Johnson, Baker, Kopala, Kiselica, & Thompson, 1989; Larson & Daniels, 1998; Morrison & Lent, 2018). That is, the field is under-utilizing self-doubt as a teaching tool, yet the potential benefits of therapists understanding self-doubt are unique (Nissen-Lie et al., 2013). As such, providing additional information regarding therapist self-doubt may further allow therapists and supervisors the ability to improve performance.

### Self-Doubt

Uncertainty regarding ability and subsequent performance is reported frequently among mental health professionals in the profession. This phenomenon has been termed in myriad ways, such as self-perceived incompetence (Davis et al., 1987), self-criticism about performance (Hill et al., 2007), feelings of incompetence (Thériault & Gazzola, 2010), and professional self-doubt (Orlinsky & Rønnestad, 2005). Despite the variety by

which it may be studied, the pervasiveness and consequences of this construct are well examined (Thériault & Gazzola, 2010). In the context of this study, professional self-doubt is operationalized as the degree to which therapists feel uncertain regarding their ability to help a client.

Self-doubt is prevalent among therapists. When asked about barriers to therapy, 42-83% of therapists reported experiencing self-doubt regarding their ability to help their clients (Mahoney, 1991; Orlinsky et al., 1999). These feelings are reported by therapists in all levels of experience but are particularly relevant among less experienced therapists (Orlinsky et al., 1999). Orlinsky and colleagues (1999) surveyed therapists of all levels of experience about self-perceived mastery and competence. Of those surveyed, 83% of therapists with less than 1.33 years of experience, 70% of therapists with between 1.33 and 3.15 years of experience, and 52% of therapists with between 3.15 and 5 years of experience reported low mastery (described and cited in Thériault & Gazzola, 2010). Therapists who do not recognize and cope with feelings of self-doubt may be unable to prevent the negative effects (e.g., burnout; Hannigan, Edwards, & Burnard, 2004). The intensity in which therapists experience self-doubt regarding mastery generally attenuates over time and experience (Skovholt & Rønnestad, 2003). On its face, self-doubt may appear to be a detrimental quality in a therapist, especially considering that it attenuates as therapists gain experience throughout their career. However, the evidence of self-doubt's effects on therapy process and outcome is more nuanced.

Without being properly harnessed and contextualized, therapist self-doubt can be harmful to the therapist, the therapy process, and the clients' outcomes. Challenges of

uncertainty and adverse consequences are intimately linked. Therapists may experience work-related stress and burnout (Farber & Heifetz, 1981; Hannigan et al., 2004), and some respond by leaving the field (Thériault & Gazzola, 2006). Further, these work-related experiences often extend into therapist's personal lives, causing additional stress (Guy, 2000). Within a therapy setting, feelings of self-doubt can negatively impact the therapeutic alliance (i.e., rapport; Watson & Greenberg, 2000). Clients may respond with disengagement and withdrawal (Brady, Guy, Poelstra, & Brown, 1996), and may even drop out of treatment entirely (Thériault & Gazzola, 2006). In other words, clients may not respond positively to therapists who are in doubt of their ability to help.

The association between self-doubt and client outcomes is complex. Despite the known adverse consequences (e.g., therapist stress, reduced therapeutic alliance), self-doubt has the potential to positively impact therapy process and outcome. Consistent with Tracey and colleague's (2014) argument, described in later sections, self-doubt can lead to positive impacts when intentionally used as healthy self-criticism. Several studies found that greater expressed self-doubt predicts better outcomes among clients (Nissen-Lie et al., 2013). The direction of impact appears to depend upon therapists' responses to said doubt (Nissen-Lie et al., 2017). Therapists who maintain self-doubt when facing challenges and barriers within the clients' context may allow them to find solutions to these barriers (Macdonald & Mellor-Clark, 2015). For example, a therapist may experience self-doubt when interacting with a client who is unmotivated, aggressive, and depressed. Upon recognizing their doubt, the therapist may engage in behaviors (e.g., reading the literature, consulting with supervisors) that lead to new methods of

interacting with the client (e.g., using a different form of therapy). Therapists must be able to recognize their own limitations and subsequently provide solutions to produce change in themselves to fit the needs of the client.

Although there is evidence supporting both the negative and positive impacts associated with self-doubt, little is known about its potential sources. For instance, it is unknown whether self-doubt exists as a state- or trait-characteristic. Certainly, there is evidence to suggest that therapists experience self-doubt longitudinally (Orlinsky et al., 1999). Nonetheless, there are conceivable instances in which self-doubt may vary by context. Therapists who frequently interact with adult clients may experience greater self-doubt, for example, when working with child clients.

There are no known, published experimental studies to date which examine the link between specific client characteristics and therapists' self-doubt. Nonetheless, there is empirical evidence that clients with intense externalizing symptoms elicit the greatest amount of self-doubt in therapists. In a series of qualitative interviews, Thériault and Gazzola (2010) elucidated novice therapists' beliefs regarding challenges to their abilities, judgement, and effectiveness. Notably, they identified client characteristics most often associated with these challenges. Among these characteristics were unmotivated, high-stakes clients, and those who are aggressive with intense emotionality. Further, they reported several labels and diagnostic criteria such as violent, suicidal, and psychotic. In such instances when therapists may experience greatest self-doubt, their personal values may be affected by client characteristics; thereby interfering with practice. For instance, when a client's behavior violates a therapist's moral values, the therapist may be unable

to objectively approach the situation and maintain professionalism. Because therapists interact closely with their clients, and client characteristics may elicit variable amounts of therapist self-doubt that have implications for therapy process and outcome, it is important to understand the conditions by which self-doubt may vary (Nissen-Lie et al., 2017).

There remains a gap in the literature regarding therapists' reactions of self-doubt to client characteristics. Therapists and supervisors may utilize therapists' healthy self-criticism, in conjunction with information regarding its sources, to find solutions. These solutions are paramount in avoiding self-doubt's harmful effects (e.g., therapist burnout, client withdrawal; Hannigan et al., 2004) in favor of those that are helpful (e.g., improved client outcomes; Macdonald & Mellor-Clark, 2015; Nissen-Lie et al., 2017).

Understanding the sources of self-doubt, therefore, provides therapists and supervisors an opportunity to explore potential solutions.

### Overcoming the Obstacles

Expertise can be achieved—rather, consistent improvement can be made—under two conditions (Kahneman & Klein, 2009). First, if the environment is predictable and contains available sources for quantifying outcomes. In other words, objective documentation of performance is reliable for future predictions only when work-related conditions are predictable. Second, when individuals have the opportunity to learn from objective documentations, further improving future outcomes. Therapists typically perform in environments in which neither of these conditions are met (Macdonald & Mellor-Clark, 2015). There are, however, well-supported methods to overcome

complications of an unpredictable environment and allow for both accurate and quantifiable feedback.

Macdonald and Mellor-Clark (2015) provide a summary of formal feedback systems and their uses among therapists. They suggest that these systems are necessary to improve performance over time. Feedback can come in many forms. It typically involves tracking client symptoms and progress through multiple structured interviews and questionnaires, but also involves therapist accountability and involvement of supervisors (Barkham et al., 2010; Duncan, Miller, & Sparks, 2004). When therapists monitor and discuss client goals and progress, they can engage in processes of problem identification and solving with greater reliability than is offered by self-assessment. Multiple forms of formal feedback systems exist, but effective systems contain common ingredients (Macdonald & Mellor-Clark, 2015). First, using structured measures provides information regarding client problems as well as any barriers to treatment. Second, discussion with the client regarding factors within therapy that may impede progress. These factors may include therapist characteristics (e.g., attitudes toward the client, approaches to therapy) or client characteristics (e.g., attitudes toward therapy, insight). Therapists' understanding of factors that may impede progress provide opportunity for them to find and practice solutions.

The Macdonald and Mellor-Clark (2015) ingredients for feedback systems are consistent with Tracey and colleagues (2014), who also argue for therapists to use playful applications of feedback. One such playful application includes avoiding confirmatory bias (i.e., overestimating self-appraisals) by adopting a disconfirmatory stance (i.e.,



pessimism toward performance quality). Confidence in one's ability to perform may be poorly related to actual performance—as previously described—but doubt in one's ability to perform yields the opposite relation (Nissen-Lie et al., 2013). The expression of self-doubt, in other words, is a consistently powerful predictor of client outcome. In this regard, self-doubt may be a method of self-appraisal that can be used in conjunction and feedback to improve therapy process and outcome, and further to continue development of expertise in therapy.

The impact of feedback systems is well-documented and highly influential to client outcomes (see Lambert, 2010 for a full review). The American Psychological Association's (APA) Taskforce on Effective Psychotherapy Relationships determined formal feedback systems to be an effective element of therapy (Norcross, 2011). Others state that formal feedback provides the lower performing therapists the ability to achieve their potential in becoming highly effective (Miller, Hubble, & Duncan, 2007). Understanding characteristics of therapists that associate to better client outcomes provides context to the discussion of targets for formal feedback.

#### Therapist Characteristics in the Therapeutic Context

Outcomes in therapy depend upon a multitude of factors that interact to influence client change. *Specific factors*, those unique to the treatment model, are undoubtedly the most commonly studied factors that produce client change (Baldwin & Imel, 2013; Wampold, 2015). Specific factors include treatment-type and adherence to protocol, for example (Bell, Marcus, & Goodlad, 2013). Other important predictors of therapy process and outcome involve *common factors*, those seen within all therapeutic contexts.

Therapeutic alliance (Horvath, Del Re, Flückiger, & Symonds, 2011), client expectations (Constantino, Arnkoff, Glass, Ametrano, & Smith, 2011), and therapist characteristics (Baldwin & Imel, 2013) are some of the well-studied common factors. Specific and common factors are unique concepts that merge to influence client change (Nissen-Lie et al., 2017; Wampold, 2015); thus, all are important considerations when understanding mechanisms of successful therapy.

Therapist characteristics—a common factor—are potentially powerful tools for not only predicting client change, but also as targets for feedback systems to achieve better performance. Therapist characteristics that predict therapy outcome can be quantified as “therapist effects” (Albert, 1997; Okiishi et al., 2006; Wampold, 2015). By understanding the conditions in which therapist effects operate, as well as the outcomes they produce, researchers may better understand the mechanisms of therapy and make more reliable and evidence-based adjustments to practice (Nissen-Lie et al., 2013).

### Therapist Effects

Just as the therapeutic intervention and common factors merge to produce outcome, effective therapists integrate their professional expertise with personal attributes to facilitate client improvement (Nissen-Lie et al., 2017). Therapists’ personal and interpersonal characteristics predict therapy outcome, including but not limited to facilitative interpersonal skills (Anderson, McClintock, Himawan, Song, & Patterson, 2016), responsiveness and empathy (Bohart, Elliott, Greenberg, & Watson, 2002), and persuasiveness (Wampold, 2015). In fact, these personal attributes better predict therapy outcome than do professional experiences (e.g., level of training, years of experience;

Tracey et al., 2014). For example, a meta-analysis of therapists' empathy (e.g., ability to adopt clients' perspectives, empathic concern for the client) indicated that clients who encounter highly empathic therapists are more likely to improve than those who do not (Elliott, Bohart, Watson, & Greenberg, 2011). A therapist who follows treatment principles but is unfriendly or hostile is likely not as effective as one who is warm and friendly.

Professional expertise and personal attributes are not entirely distinct, however. Over time, therapists tend to integrate their personal characteristics within their professional work, thereby improving performance (Nissen-Lie et al., 2017). Therapists who are empathetic, convincing, and trustworthy are more likely to produce change among their clients than those who lack those traits (Tracey et al., 2014). Over time and experience, therapists may find ways to integrate these strengths into practice, thereby continually improving. For instance, therapists may recognize aspects of their own personal style (e.g., patience) that serve as effective therapeutic tools in a given context (e.g., working with children), thereby giving them ample opportunity practice these tools within their professional work (e.g., planned-ignoring). To reliably facilitate this integration among the general population of therapists, however, requires intentional and directed adjustments to targeted characteristics.

The interaction of therapist and client characteristics is an important consideration in client outcomes and is particularly evident when examining therapist effects in relation to client symptom severity. Most therapists yield similar outcomes with clients who present with less severe symptoms (Saxon & Barkham, 2012). The more severe the

clients' symptoms, however, the more their outcome depends on whether they were assigned to a higher performing therapist—those who facilitate, on average, better client outcomes. The contribution of client symptom severity toward therapist effects on outcomes remains inconclusive, as one recent study did not find severity to significantly interact with therapist characteristics (Dinger, Zimmermann, Masuhr, & Spitzer, 2017). Considering the disparity in these results, symptom-type in addition to symptom severity may be important factors that impact the interaction of therapist and client characteristics.

Multiple characteristics reliably distinguish therapists who are more and less effective (Saxon & Barkham, 2012; Saxon, Barkham, Foster, & Parry, 2017). Characteristics that signify more effective therapists appear to be reliable—those that are effective in one outcome domain are likely to be effective in other domains (Kraus, Castonguay, Boswell, Nordberg, & Hayes, 2011; Nissen-Lie et al., 2016). For example, higher performing therapists consistently foster strong alliances with a range of clients (Zuroff, Kelly, Leybman, Blatt, & Wampold, 2010), have a high level of facilitative interpersonal skills (Anderson et al., 2016), engage in more time practicing therapy skills outside the context of therapy (Wampold, 2015), and express *more* professional self-doubt (Nissen-Lie et al., 2013). Understanding and exploring the sources of these reliable indicators for therapist performance serve as potential targets for both self-improvement as well as formal feedback.

#### Conduct Disorder as a Source of Self-Doubt among Therapists

The qualitative evidence provided by Thériault and Gazzola (2010) is far from exhaustive regarding the potential sources of professional self-doubt. Regardless, it is

invaluable information that can be further used to understand conditions in which therapists' self-doubt vary according to client characteristics. Thus, clients who are subjectively described by therapists as high-stakes, unmotivated, aggressive, violent, and those that violate the morals of therapists are especially implicated in producing the greatest amount of therapist self-doubt. Conduct disorder (CD) among adolescents provides a representative illustration of these qualities.

### Conduct Disorder

A diagnosis of CD requires a persistent pattern of behavior that is a violation of the rights of others and, further, conflicts with societal norms and authority figures (American Psychiatric Association [APA], 2013). The presence of aggression is central to a diagnosis. Specifiers, symptomatology, and severity often characterize subgroups of youth, such as those who are unmotivated with intense emotionality. This disorder represents a severe manifestation of externalizing behavior that pervades all domains of life, including those of family, peers, school, and work (Kimonis, Frick, & McMahon, 2014). Three of 15 symptoms are required to meet diagnostic threshold for CD, with more symptoms representing a more severe manifestation of the disorder (see Appendix A). The symptoms of CD represent a consistent pattern of behaviors within four dimensions: aggression to people and animals; destruction of property; deceitfulness or theft; and serious violations of rules (APA, 2013). Although symptoms along these dimensions are also seen in other manifestations of mental illness, they manifest together in CD.

The prevalence of CD varies by subgroup of youth. Overall consideration of gender, adolescent boys are subject to the highest prevalence (Loeber, Burke, Lahey, Winters, & Zera, 2000). However, the disparity in diagnosis for boys and girls only becomes distinctly present in elementary-aged children (i.e., 7-8 years-old). A review of the literature suggests that CD—by gender—is equivalent until about school age (i.e., 5 years-old; Maughan, Rowe, Messer, Goodman, & Meltzer, 2004). After school age, boys are about twice as likely to be diagnosed with CD (Lavigne, Lebailly, Hopkins, Gouze, & Binns, 2009). Compared to community samples, youth exhibit CD at a much greater rate among clinical samples (e.g., detained youth). To illustrate this phenomenon, epidemiological research on CD reported the prevalence rate in community samples to be 2-5% (Boylan, Vaillancourt, Boyle, & Szatmari, 2007; Loeber et al., 2000). Researchers using clinical interviews of detained youth, in contrast, reported that approximately 40% met criteria for CD (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002). Surprisingly, some estimates were as high as 60% (Fazel, Doll, & Långström, 2008). Regardless of the environment from which the sample is drawn, adolescent boys tend to compose the largest percentage of children with CD.

Delinquent behavior generally increases from childhood into adolescence and adulthood. A study performed in New Zealand examined observer reports (i.e., parent, teachers) of conduct problems for children across a 3-year period, with a 25-year follow-up (Fergusson, Horwood, & Ridder, 2005). The greater the severity of conduct problems at the time of measurement predicted more adverse effects in adulthood: higher rates of crime (e.g., violent offending), substance use (e.g., illicit drugs), mental health problems

(e.g., suicide attempts), and sexual/partner relationships (e.g., inter-partner violence). The presence of conduct problems in youth predicts impairment from early adulthood to late life, with worse outcomes associating to earlier development of problem behaviors. Consistent with this notion, children younger than 10 years old who are diagnosed with CD (i.e., childhood-onset) are more likely to commit violent and drug offenses in adulthood than those who are diagnosed in adolescence (i.e., adolescent-onset; Odgers et al., 2008). Although adolescent boys tend to represent the majority of children diagnosed with CD, the worse outcomes tend to be for those diagnosed in childhood.

#### Conduct Disorder as Source of Self-Doubt

Conduct disorder is likely to elicit a large amount of self-doubt in therapists, considering its significant overlap with the qualitative information provided by Thériault and Gazzola (2010). To reiterate, self-doubt was greatest in response to the subjective descriptions of clients who possess intense emotionality, and those who are unmotivated, high-stakes, aggressive, violent, and suicidal. Notably, it is likely that behaviors characterized by these symptoms may violate the personal values of the therapist—leading to situations in which the therapist is unable to maintain objectivity and, further, therapeutic distance.

Although the heterogeneity of symptoms and impairment among youth with CD is high (Kimonis et al., 2014), self-doubt is likely to vary across symptom-type, specifier, and severity of the disorder. Regarding symptom-type, more aggressive, violent, and destructive behaviors may elicit greater self-doubt than deceitfulness, violation of norms, and theft. For instance, a therapist may find it easier to treat adolescents who are often

truant from school, bully others, and lie to avoid obligations than those who use weapons to harm others, have broken into someone's house, and have forced someone into sexual activity.

Further, therapist self-doubt may vary by specifier of the disorder. Specifiers capture subgroups of youth who exhibit limited prosocial emotions. These specifiers include lack of remorse or guilt, callous-lack of empathy, being unconcerned about performance, and shallow or deficient affect (APA, 2013). Aligning with responses described by Thériault and Gazzola (2010), youth who are unconcerned about performance may be seen as unmotivated. Further, youth who are not remorseful in terms of their delinquent behaviors may violate the morals of the therapist. Therapists, accordingly, are likely to respond with more confidence to youth who have higher motivation and admit remorse.

Conduct disorder is unique from most other psychiatric disturbances because violation of other's rights and societal norms is central to a diagnosis (APA, 2013; Kimonis et al., 2014). The disorder presents most often in youth who are, arguably, among the most vulnerable populations for lifelong impairment resulting from complications of CD. Because the criteria and specifiers of CD largely encapsulate known associations of self-doubt, it is a strong candidate for eliciting the self-doubt among therapists. There are currently no known published studies describing disorders for which self-doubt is least among therapists. It is, therefore, prudent to investigate conditions in which therapists' self-doubt may vary in response to different manifestations of mental illness.



## CHAPTER 2

### CURRENT STUDY

Achieving expertise in therapy is fraught with obstacles which may impede or hinder progress, but well-supported solutions are available in the form of feedback systems (Tracey et al., 2014; Macdonald & Mellor-Clark, 2015). Because self-doubt predicts client outcomes and may be used to surpass the inaccuracy of self-appraisal, self-doubt may be a viable target for feedback (Nissen-Lie et al., 2013, 2016, 2017; Macdonald & Mellor-Clark, 2015). Professional self-doubt is operationalized as the degree to which therapists feel uncertain regarding their ability to help a client. Little is known, however, about therapists' self-doubt regarding influential factors such as client and therapist characteristics. Additionally, little is known about self-doubt's association with other constructs widely used among developing therapists. There is evidence that self-doubt is greatest in response to adolescents with conduct disorder (Thériault & Gazzola, 2010).

The current study primarily aims to investigate differences in therapist trainees' self-doubt in terms of treating CD. Therapist characteristics (e.g., empathy) are highly predictive of client outcomes. As such, exploratory analyses will aim to clarify self-doubt's relation to therapists' interpersonal reactivity (e.g., empathic concern, perspective taking; Davis, 1983). Because other self-appraisal instruments are commonly used to conceptualize therapist's development and maturation, exploratory analyses will also aim to clarify self-doubt's relation to therapist self-efficacy (Lent et al., 2003). Further, this study aims to generate research on self-doubt as a target for feedback systems in the quest

to improve expertise in therapy, overall. Students in clinical mental health counseling master's programs within the United States were investigated; considering much of the research on self-doubt has primarily focused on master's level therapists (e.g., Nissen-Lie et al., 2013; Thériault & Gazzola, 2010), and self-doubt is generally highest among inexperienced therapists (Orlinsky et al., 1999).

Participants in the current study read and responded to four vignettes portraying scenarios of adolescent boys with mental illness, in a within-subjects design. Self-doubt was assessed after each vignette using a measure constructed and validated for developing therapists (Orlinsky & Rønnestad, 2005). One vignette depicted a boy with aggressive symptoms and callous-unemotional traits of CD, and another depicted a boy with nondestructive and nonviolent symptoms of CD. As a comparison, two vignettes likewise depicted boys with internalizing disorders. One vignette depicted a boy with obsessive-compulsive disorder (OCD), and another depicted a boy with social anxiety disorder (SAD). Ancillary measures assessed aspects of interpersonal reactivity (i.e., empathic concern, perspective taking; Davis, 1983) and therapist self-efficacy (Lent et al., 2003). The hypotheses are as follows:

- a. There will be group differences in self-doubt between vignettes. It is expected that participants will find it most difficult to treat adolescent boys who portray more aggressive/callous-unemotional symptoms of CD, less difficult to treat adolescent boys who portray symptoms of OCD or nonaggressive CD, and least difficult to treat adolescent boys with SAD.

- b. There will be a positive correlation between therapist's perspective taking and the estimate of overall self-doubt.
- c. There will be a positive correlation between therapist's empathic concern and the estimate of overall self-doubt.
- d. There will be a negative correlation between therapist's self-efficacy for session management and the overall expression of self-doubt.
- e. There will be a negative correlation between therapist's self-efficacy of counseling challenges and the overall expression of self-doubt.

## CHAPTER 3

### METHOD

#### Participants

An *a priori* power analysis using G\*Power version 3 (Faul, Erdfelder, Lang, & Buchner, 2007) estimated that a sample of 36 participants was necessary to detect a moderate effect in a within-subjects ANOVA. The parameters for the power analysis were as follows: medium effect size ( $f = .25$ ), error probability ( $\alpha = .05$ ), power ( $1 - \beta = .95$ ), one group, and four measurements. More than 36 participants were recruited to maximize power as well as account for missing data, dropout, and nonresponses.

Participants were 67 graduate students within clinical mental health counseling master's programs in Universities across the United States. Ten programs were randomly chosen from an exhaustive list of terminal clinical mental health counseling master's programs in the United States. Participants were excluded if they were not master's level trainees. According to *a priori* procedure, given the first ten programs fails to yield a total of 75 participants, a second wave of an additional 10 programs were to be randomly chosen from the same list. To obtain the sufficient number of participants, 160 program coordinators were contacted. Because program coordinators did not often respond via email to the request, it is impossible to calculate a response rate; however, because such a large number of programs were contacted, it is likely the response rate is extremely low. Participants received \$8 for approximately 15 minutes of participation. This level of pay translates to \$32 per hour of participation. The high level of pay was intended to motivate participants to attend closely to the survey.

Participants age ranged from 21 to 61 years of age ( $M = 27.49$ ,  $SD = 8.25$ ). The majority of participants were female (83.6%,  $n = 56$ ). The majority of participants were Caucasian/White (80.6%,  $n = 54$ ). Additionally, 31.3% were in their first year of their graduate program ( $n = 21$ ), 37.3% were in their second year ( $n = 25$ ), 26.9% were in their third year or later ( $n = 18$ ), and 4.5% did not respond to that item ( $n = 3$ ). Participants labeled a range of theoretical orientations and activities which they typically run in therapy sessions. Approximately one-third identified as having the orientation of cognitive behavior therapy, one-third as eclectic, and the remainder as psychodynamic, Adlerian, humanistic, and feminist. See Table 1 for participants' demographic characteristics.

Table 1

*Demographic Characteristics*

Demographics	Total	Percentage	Mean (SD)
<b>Gender</b>			
Male	9	13.8%	
Female	56	86.2%	
Missing	2	3.0%	
<b>Age</b>			27.49 (8.25)
21-26	44	67.7%	
26-61	21	33.3%	
Missing	2	3.0%	

(table continues)

Demographics	Total	Percentage	Mean (SD)
<b>Year</b>			
First	21	31.3%	
Second	25	37.3%	
Third or Later	18	26.9%	
Missing	3	4.5%	
<b>Currently Seeing Clients</b>			
Yes	31	46.3%	
No	34	50.7%	
Missing	2	3.0%	
<b>Race/Ethnicity</b>			
African American/Black	4	6.0%	
Asian American	1	1.5%	
Caucasian/White	54	80.6%	
Latin-X/Hispanic	8	11.9%	
Native American	2	3.0%	
Missing	2	3.0%	

### Procedure

An email was sent to the program coordinators of each institution intended to be included within this study, requesting permission to recruit students. Program coordinators were asked to forward an email to the students, containing a description of the study and a link to an online survey webpage (i.e., Qualtrics). After providing consent, participants moved on to a series of four vignettes describing different scenarios (see Appendix B). The vignettes are the independent variables within this study. The order of the vignettes were randomized to limit maturation and order effects. Participants viewed the vignettes; each followed by the professional self-doubt scale, the dependent variable, as well as an item inquiring participants about how difficult it may be to treat the client (see Appendix C). The content of the professional self-doubt scale was the same, except that names were individualized for each vignette. After completing the vignettes and subsequent self-doubt scales, participants completed the interpersonal reactivity index and counseling activities self-efficacy scale, as well as a brief demographics survey. Two attention check items were included, one appeared within a professional self-doubt scale and one appeared within the interpersonal reactivity index. Upon completion of the procedures, participants were given the option to list their email addresses to obtain compensation. Participants were informed that, once they confirmed compensation, their email addresses would be deleted from the data set.

## Measures

### Vignettes

All vignettes were created by the investigator for the purpose of this study (see Appendix B). Administration of four vignettes allowed therapist trainees to respond to various conditions and presenting problems. This variety provided information to understand how self-doubt varies between and within manifestations of mental illness. The qualities described by Thériault and Gazzola (2010) to elicit the greatest amount of self-doubt were the inspiration for the content in these vignettes. Because these qualities largely depict externalizing behaviors, comparison vignettes of internalizing behaviors were included—with internalizing behaviors hypothesized to elicit less self-doubt, overall, than externalizing behaviors. Additionally, because these qualities depict relatively hard-to-treat behaviors, comparison with relatively easy-to-treat behaviors were included—with easy-to-treat behaviors hypothesized, overall, to elicit less self-doubt than hard-to-treat behaviors. The level of treatment difficulty was determined using expert review. Six clinical psychology graduate students and one clinical psychology faculty rated four vignettes in terms of their difficulty in treatment. The vignette of aggressive CD was highest, followed in order by OCD and nonaggressive CD equally, and finally SAD.

Therapist trainees' self-doubt may vary according to age and gender; therefore, all vignettes were matched on these characteristics. The age of 14 years was chosen for two reasons. First, the prevalence of CD is greatest among adolescents (Kimonis et al., 2014; APA, 2013). Second, the prognosis for childhood- rather than adolescent-onset CD



is poorer. The gender was chosen because CD prevalence is highest among boys (Kimonis et al., 2014). The names were selected based on the most popular boy names of babies in the USA in the year 2005 (Social Security Administration, 2015). The number of symptoms, gender, age, as well as word-counts were matched for each vignette. Sentence structure varies by vignette to limit maturation and order effects. That is to say, the sentence structure varies by vignette to allow for difference in prose. Because the vignettes were controlled for age, gender, and structure, any variation in self-doubt is likely due to variation in symptom presentation.

Conduct disorder vignettes. Two vignettes depicted individuals with CD. Vignette one illustrated characteristics described by Thériault and Gazzola (2010) to elicit the greatest level of therapist self-doubt. Rather than depict all qualities within this list, the characteristics reflecting unmotivated, aggressive, and callous-unemotional behaviors were particularly focused. These behaviors were of focus because criteria captured aggressive presentations of CD, and specifiers illustrated callous-unemotional traits. The second vignette reflected qualities dissimilar to those described by Thériault and Gazzola (2010), as the behaviors were nonaggressive, motivated, and remorseful.

Obsessive compulsive disorder vignette. OCD was chosen as a comparison for three reasons. First, OCD is an internalizing disorder, dissimilar to CD in core symptomatology. For instance, adolescents with OCD are not likely to exhibit acts of antisocial or aggressive behavior. Second, the prognosis for OCD among adolescents is poor, as untreated OCD is chronic (APA, 2013). In other words, symptoms/behaviors associated with OCD are not transient. Like CD, adolescents with OCD typically

maintain a diagnosis unless interventions reduce symptoms. Third, OCD and CD are not often co-occurring conditions.

Social anxiety disorder vignette. SAD was chosen as a comparison for three reasons. First, SAD is an internalizing disorder, and is dissimilar to both CD and OCD in symptomatology. People with SAD are not likely to exhibit either antisocial behavior, or persistent obsessions and/or compulsions. Second, SAD does not often co-occur with either OCD or CD (APA, 2013). Third, expert review ranked SAD similar to nonaggressive CD in terms of difficulty to treat.

#### Professional Self-Doubt Scale

The Professional Self-Doubt (PSD) scale consists of nine items that originated from the Development of Psychotherapists Common Core Questionnaire (DPCCQ; Orlinsky et al., 1999). The DPCCQ was created using qualitative research processes to develop an initial list of items that were then given to 4,923 therapists. Therapists' level of training, years of experience, and area of interest was heterogenous in this sample. A principal component analysis yielded three reliable factors, one of which was professional self-doubt (Orlinsky & Rønnestad, 2005; see Appendix C). Only the PSD scale was given in the present study, because of its association with therapeutic change. Responses are given on a six-point Likert-type scale ranging from 0 (*never*) to 5 (*very often*). Responses were modified for this study to 0 (*none-at-all*) to 5 (*completely*). The change in response type was made because the original scale was produced to obtain a general estimate of self-doubt rather than in response to specific clients. Response type was also modified to account for the four different names used in the vignettes. PSD

obtained an adequate internal consistency value in a diverse sample of therapists (Cronbach's alpha = .90; Orlinsky & Rønnestad, 2005). All four PSD scales had sufficient reliability within this dataset (Cronbach's alpha ranging from .84-.88).

### Interpersonal Reactivity Index

Many instruments are available to assess empathy, but the most widely used and supported is the Interpersonal Reactivity Index (IRI; Davis, 1983; see Appendix D). The IRI is a multidimensional assessment of empathy, and empathy's association to social functioning, self-esteem, emotionality, and sensitivity to others. This index possesses 29 items in four scales, each scale being a unique factor of empathy. These factors are (1) empathic concern, (2) perspective taking, (3) fantasy, and (4) personal distress. Responses are given as A (*does not describe me well*) to E (*describes me very well*) on a five-point Likert scale. Only the Perspective Taking and Empathic Concern subscales were included in analyses. Assessing the hierarchical structure of the IRI, researchers found reliability of the scales to be adequate (empathic concern, alpha = .80; perspective taking, alpha = .79; Pulos, Elison, & Lennon, 2004). The Empathic Concern and Perspective Taking subscales had sufficient reliability within this dataset (Cronbach's alpha of .78 and .79, respectively).

### Counselor Activity Self-Efficacy Scale

Few instruments are available to assess the level of confidence or doubt that therapists experience throughout their development in therapy contexts. The Counselor Activity Self-Efficacy Scale (CASES) was developed in an effort to understand the progression and impact of self-efficacy on both therapy skills and career development of

counselors (Lent et al., 2003; see Appendix E). The 41 items of the CASES assesses the six, related self-efficacy factors of exploration skills, insight skills, action skills, session management, client distress, and relationship conflict. These factors were further clustered within subscales: insight skills, exploration skills, and action skills compose Helping Skills subscale; Session Management composes its own subscale; and client distress and relationship conflict compose the Counseling Challenges subscale. For the purposes of this study, to examine self-efficacy associated with managing challenging clients in a session, only the Session Management and Counseling Challenges subscales were included in data collection. The responses are on a 10-point Likert-type scale ranging from 0 (*No Confidence*) to 9 (*Complete Confidence*). The Session Management scores indicate the extent to which therapists believe they are capable of facilitating successful therapy sessions. The Counseling Challenges scores indicate the extent to which therapists believe they are capable of overcoming interpersonal or other potential conflicts with clients. The Session Management and Counseling Challenges subscales had sufficient reliability within this dataset (Cronbach's alpha of .93 and .91, respectively).

### Demographics

The demographics questionnaire assessed age, gender, race/ethnicity, level of training (i.e., year in the program), the number of contact hours with clients, and the number of contact hours with clients with CD, OCD, and SAD (see Appendix F). This questionnaire was designed by the current author for the purpose of this study.

### Attention Checks

Attention checks were included to test participants' attention to items (see Appendix F). Attention checks are typically used in situations where attention to items is necessary for the accurate measurement of manipulations (Oppenheimer, Meyvis, & Davidenko, 2009). The response was used as a measure of whether participants are paying attention to the content of the items and responding appropriately. In this instance, two attention checks were included. Participants were excluded from final data analysis if both attention checks were failed to better ensure all those included within analyses fully attended to items.

### Statistical Analysis and Preparation

After data collection was completed, the dataset was cleaned and prepared for analyses. The first step was to remove participants' data that did not meet the *a priori* criteria. Nineteen participants' data were removed from the dataset because 15% or more of the responses were missing (Horton & Kleinman, 2007). In addition, the mean time that participants took to complete the experiment was calculated. Originally, it was planned to exclude participants whose time to completion exceeded three standard deviations from the mean; however, no participant's data were excluded due to this criterion. Note, for all correlational analyses, Cohen's (1992) guidelines for small ( $r = .10$ ), medium ( $r = .30$ ), and large ( $r = .50$ ) correlations was used.

The second step was to calculate mean scores for each scale and subscale in preparation for analyses. Professional Self-Doubt (PSD) scale total scores were calculated by averaging across the nine items for each vignette. Because the PSD scale

had sufficient reliability within this dataset (Cronbach's alpha ranging from .84-.88), total scores were calculated for participants missing up to two items (Horton & Kleinman, 2007). There are a total of five PSD scores per participant: four scores reflect the four averages from each of the vignettes, and one score is the average all four responses. Because this study only examined PSD in response to vignettes, rather than PSD regarding all counseling activities, this average score provides an estimate of the PSD scale scores per person.

The mean score for the Interpersonal Reactivity Index subscales termed Empathic Concern (IRI-EC) and Perspective Taking (IRI-PT), were calculated by averaging across the seven items in each subscale. Because the IRI-EC and IRI-PT subscales did not have sufficient reliability within this dataset to allow for missing items (Cronbach's alpha of .78 and .79, respectively), total scores were calculated only for participants who responded fully to the subscales.

The mean score for the Counseling Activity Self-Efficacy subscales termed Session Management (CASES-M) and Counseling Challenges (CASES-C), were calculated by averaging across the 10 and 14 items, respectively. Because the CASES-M and CASES-C subscales had sufficient reliability within this dataset (Cronbach's alpha of .93 and .91, respectively), total scores were calculated for participants missing up to two items.

For primary analysis, the dataset was screened for the following assumptions, consistent with those required by repeated measures ANOVA: a) the sample must be approximately normally distributed; b) there should be no significant outliers; and c) the

variances of related groups must be equal (i.e., sphericity). The sample was approximately normally distributed for each value of PSD, evidenced by skewness statistics ranging from .947 to 3.219—none of which exceeded the 3.29 limit. There was one significant outlier for PSD-OCD vignette; that participant was excluded from primary analyses. Last, the sphericity assumption was violated, Mauchly's  $W(5) = .678$ ,  $p < .001$ . As a result, because epsilon was greater than .75, the Huynh-Feldt correction was applied to alter the degrees of freedom and establish an  $F$ -ratio in which Type I error is reduced (Girden, 1992; Huynh & Feldt, 1976).

## CHAPTER 4

### RESULTS

#### Primary Analyses

##### Hypothesis One

Hypothesis one specified that there would be group differences in self-doubt between vignettes. More specifically, in terms of the PSD scores following each vignette, participants were expected to have the greatest self-doubt in response to CD-Severe, then CD-Mild and OCD (equally), and finally SAD. In other words, it was expected that participants would find it most difficult to treat adolescent boys who portray more aggressive/callous-unemotional symptoms of CD, less difficult to treat adolescent boys who portray symptoms of OCD or nonaggressive CD, and least difficult to treat adolescent boys with SAD.

A repeated measures ANOVA determined that there was a statistically significant effect of vignette-type on the degree to which participants endorsed professional self-doubt,  $F(3, 60) = 55.68, p < .001$ , partial  $\eta^2 = .473$ . In line with the hypothesis, planned comparisons revealed that participants viewed the vignette which portrayed an adolescent with CD-Severe, with the greatest self-doubt ( $M = 2.721$ ). Professional Self-Doubt scores associated with the CD-Severe vignette were significantly greater than those associated with OCD ( $M = 1.940; p < .001$ ), CD-Mild ( $M = 1.912; p < .001$ ), and SAD ( $M = 1.644; p < .001$ ). Further planned comparisons revealed that participants' PSD did not differ between those of OCD ( $M = 1.940$ ) and CD-Mild ( $M = 1.912; p = 1.00$ ). Last, planned comparisons revealed that participants viewed SAD with the least self-doubt ( $M = 1.644$ )



when compared to with CD-Severe ( $M = 2.721$ ;  $p < .001$ ), OCD ( $M = 1.940$ ;  $p < .001$ ), and CD-Mild ( $M = 1.912$ ;  $p < 0.01$ ). See Table 2 as well as the Figure for an illustration.

Table 2

*Bonferroni Post Hoc Analyses of PSD by Vignette*

Vignette		Mean		$p$	95% Confidence Interval		Effect Size (Cohen's $d_z$ )
		Difference	Std. Error		Lower	Upper	
	CD-M	0.059	0.079	1.00	-0.157	0.275	-0.048
	SAD	0.316***	0.066	.000	0.136	0.496	-0.615
CD-Severe	OCD	0.755***	0.111	.000	0.453	1.057	-0.951
	CD-M	0.814***	0.091	.000	0.566	1.062	-1.191
	SAD	1.071***	0.099	.000	0.802	1.364	-1.475
CD-Mild	OCD	-0.059	0.079	1.00	-0.275	0.157	0.048
	CD-S	-.0814***	0.091	.000	-1.062	-0.566	1.191
	SAD	0.257*	0.079	.011	0.042	0.472	-0.432
SAD	OCD	-0.316***	0.066	.000	-0.496	-0.136	0.615
	CD-S	-1.071***	0.099	.000	-1.340	-0.802	1.475
	CD-M	-0.257*	0.079	.011	-0.472	-0.042	0.432

\*  $p < .05$ , \*\*  $p < .01$ , \*\*\*  $p < .001$

Based on observed means.

The error term is Mean Square (Error) = 1.495.

The mean difference is significant at the .05 level.

Note: SAD = Social Anxiety Disorder Vignette; CD-S = Conduct Disorder, Severe Vignette; CD-M = Conduct Disorder, Mild Vignette; OCD = Obsessive-Compulsive Disorder Vignette

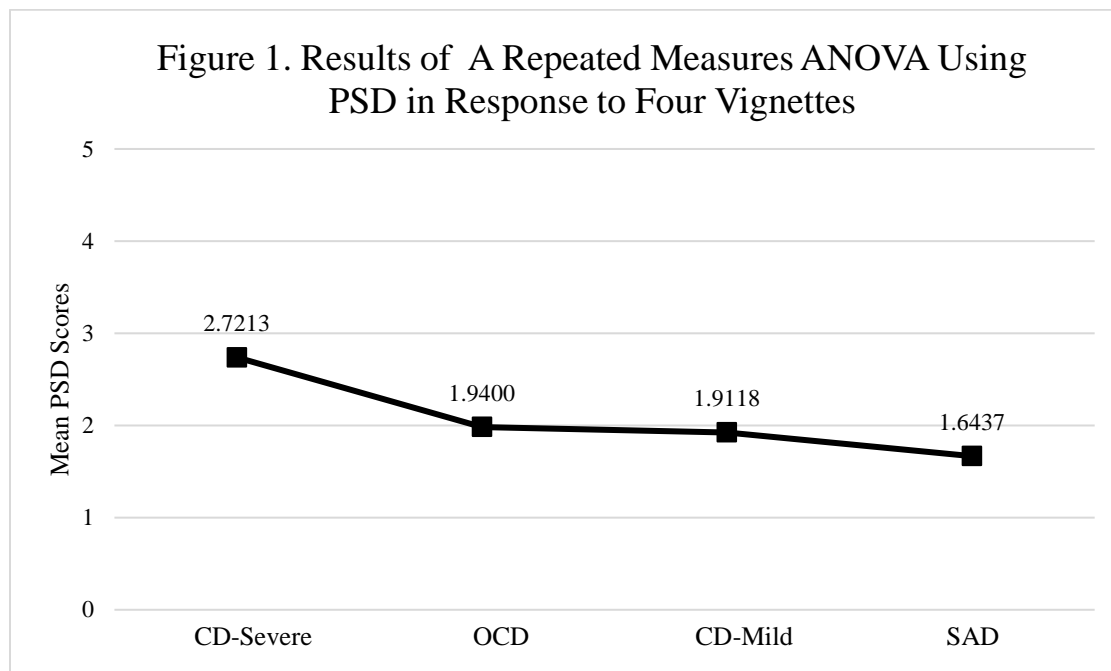


Figure 1 Mean values are displayed for Professional Self-Doubt scores in response to the vignettes illustrating adolescent boys with conduct disorder-severe (CD-Severe), obsessive compulsive disorder (OCD), conduct disorder-mild (CD-Mild), and social anxiety disorder (SAD).

#### Hypothesis Two, Three, and Four

As stated in the second hypothesis, it was predicted that there would be a positive correlation between therapists' perspective taking (IRI-PT) and the overall expression of PSD. This hypothesis was significant,  $r = -.315$ ,  $p = .012$ , with a medium negative

correlation. In other words, the greater the tendency to adopt the perspective of another person associated with lower overall levels of self-doubt.

As stated in the third hypothesis, there would be a positive correlation between participants' empathic concern (IRI-EC) and the overall expression of PSD. This hypothesis was not significant,  $r = .161, p > .05$ . In this sample, being oriented towards others' emotions does not appear to relate to participants' feelings of self-doubt in therapeutic settings.

As stated in the fourth hypothesis, there would be a negative correlation between participants' PSD and counseling activities self-efficacy, measured by the CASES. Professional Self-Doubt yielded a medium, negative correlation with CASES-M,  $r = -.480, p < .001$ . Similarly, PSD yielded a large, negative correlation with CASES-C,  $r = -.569, p < .001$ . See Table 3 for all correlations.

Table 3

*Correlation Matrix for Scores on the PSD Scales via Vignettes, Mean PSD Score, CASES, as well as EC and PT Scales of the IRI*

Measure	1	2	3	4	5	6	7	8
1. PSD (SAD)	—	.	.	.	.	.	.	.
2. PSD (CD-S)	.60***	—	.	.	.	.	.	.
3. PSD (CD-M)	.53***	.68***	—	.	.	.	.	.
4. PSD (OCD)	.66***	.48***	.54***	—	.	.	.	.
5. IRI-EC	.07	.27*	.08	.05	—	.	.	.
6. IRI-PT	-.30*	-.21	-.32*	-.27*	.16	—	.	.
7. CASES-M	-.43***	-.43***	-.43***	-.32**	-.08	.26*	—	.
8. CASES-C	-0.44***	-0.56***	-.49***	-.35**	-.17	.45***	.78***	—
9. PSD (Mean)	.81***	.87***	.83***	.78***	.16	-.32*	-.48***	-.57***

*Note.* Intercorrelations for clinical/mental health counseling students ( $n = 65$ ) are presented below the diagonal line. For all scales, higher scores are indicative of more

extreme responding in the direction of the construct assessed. PSD = Professional Self-Doubt; SAD = Social Anxiety Disorder Vignette; CD-S = Conduct Disorder, Severe Vignette; CD-M = Conduct Disorder, Mild Vignette; OCD = Obsessive-Compulsive Disorder Vignette; IRI-EC = Interpersonal Reactivity Index, Empathic Concern; IRI-PT = Interpersonal Reactivity Index, Perspective Taking; CASES-M = Counselor Activity Self-Efficacy Scale, Manage; CASES-C = Counselor Activity Self-Efficacy Scale, Challenge.

\* $p < .05$  \*\* $p < .01$  \*\*\* $p < .001$

### Exploratory Analyses

To better clarify therapist trainees' characteristics which explain the patterns of PSD in response to vignettes, correlations were calculated for each of the dependent variables and the PSD scores per vignette (see Table 3). Notably, there was one small, significant correlation between therapists' IRI-EC and PSD scores. More specifically, the relation between IRI-EC and PSD in response to CD-Severe was significant,  $r = .272$ ,  $p = .030$ . Participants who were more concerned with the welfare of others typically rated more PSD in response to working with adolescent boys who portrayed callous-unemotional symptoms of CD. However, IRI-PT was significantly correlated with a myriad of other scales and subscales. Notably, IRI-PT correlated with PSD in response to SAD ( $r = -.299$ ,  $p = .017$ ), CD-Mild ( $r = -.218$ ,  $p = .011$ ), and OCD ( $r = -.265$ ,  $p = .036$ ). Additionally, participants who possessed a heightened sense of self-efficacy in one domain typically did so in another, evidence by a large, significant correlation,  $r = .777$ ,  $p < .001$  between CASES-C and CASES-M. Last, participants PSD values between each

vignette yielded large, significant correlations (see table 3; ranging from  $r = .477, p < .001$  to  $r = .675, p < .001$ ). Stated differently, participants who rated higher values of PSD in response to one vignette typically did so in the others.

Participants within this sample primarily identified themselves as women (83.6%); therefore, an exploratory analysis was conducted to determine whether excluding men maintained the aforementioned results. Similar to the analysis in hypothesis one, the sphericity assumption was violated and epsilon was greater than .75; therefore, the Huynh-Feldt correction was applied (Girden, 1992; Huynh & Feldt, 1976). A repeated measures ANOVA revealed that their PSD differed across the vignettes,  $F(3, 53) = 43.169, p < .001$ , partial  $\eta^2 = .440$ . Post hoc comparisons illustrated greatest PSD in response to CD-Severe, then OCD and CD-Mild equally, followed by SAD. In other words, similar results were obtained for analyses which included only women.

To understand the effect that seeing clients may have on PSD, an exploratory analysis was conducted using a within-between repeated measures ANOVA. In fact, approximately 50% of participants had not yet seen their first client ( $n = 34$ ), whereas about 46% of participants had started seeing clients ( $n = 31$ ). Similar to prior analyses, the sphericity assumption was violated and epsilon was greater than .75; therefore, the Huynh-Feldt correction was applied (Girden, 1992; Huynh & Feldt, 1976). A repeated measures ANOVA revealed that PSD differed across vignettes to a similar extent for those who were seeing clients and those who were not seeing clients,  $F(2.507, 53) = .433, p > .05$ , partial  $\eta^2 = .007$ . An independent samples  $t$ -test was also conducted to test whether the overall expression of PSD differed between those who were seeing clients

and those who were not. There was no statistically significant effect,  $t(63) = -.630, p > .05$ . In other words, whether or not participants were seeing clients, they exhibited similar levels of PSD—both overall as well as in response to the four vignettes.

## CHAPTER 5

### DISCUSSION

#### General Discussion

Professional self-doubt (PSD) has value in helping therapists recognize the beliefs that they hold concerning their inability to aid in client improvement (Nissen-Lie et al., 2013, 2016, 2017). There is evidence that PSD may serve as an instrument in eliciting accurate self-appraisals, which may provide useful information that therapists and supervisors need when seeking targets for improvement (Macdonald & Mellor-Clark, 2015). Most research on PSD has focused on its prevalence (Orlinsky et al., 1999) as well as its effects on client outcomes (Nissen-Lie et al., 2017), therapist burnout (Guy, 2000), and therapeutic alliance (Watson & Greenberg, 2000). In contrast, little is known about (a) client characteristics which influence PSD, (b) therapist characteristics which influence PSD, and (c) PSD's relation to similar constructs. Because of PSD's potential to assist in improving client outcomes and therapist development (Nissen-Lie et al., 2017), it was sensible to investigate the contributing factors which influence PSD among therapists.

The current study primarily investigated the differences in therapist trainees' expression of PSD in response to treating adolescent boys with various manifestations of psychopathology. Additionally, the current study investigated the contribution of therapist characteristics in the expression of PSD as well as its discriminant validity with a well-known measure of self-efficacy. These findings may add to the extant literature regarding the potential sources of PSD (i.e., client and therapist characteristics), the

psychometric properties of an instrument measuring PSD (i.e., discriminant validity), and the potential applicability of PSD in clinical contexts (e.g., tools for self-appraisal in continual improvement).

To understand whether client characteristics play a role in eliciting PSD, therapist trainees in the current study completed a measure of PSD in response to—hypothetically—treating four teenagers with different manifestations of mental illness. Therapist trainees responded to vignettes portraying adolescent boys with conduct disorder-severe (CD-Severe), conduct disorder-mild (CD-Mild), obsessive-compulsive disorder (OCD), and social anxiety disorder (SAD). It was hypothesized that, overall, PSD would be greatest in response to the externalizing, rather than internalizing problems. In other words, therapist trainees would find it more difficult to treat those with disruptive and impulsive behavioral issues than those with emotional disturbances.

The primary hypothesis was supported by the data. Therapist trainees expressed the most PSD in response to CD-Severe, followed equally by OCD and CD-Mild, and finally SAD with the lowest level of PSD. These findings support the qualitative evidence on client characteristics which influence novice therapists' PSD; clients who are subjectively described as unmotivated, high-stakes, aggressive, and violent (Thériault & Gazzola, 2010). The relative position of the externalizing disorders was higher than that of the internalizing disorders. In terms of PSD, the subjectively mild form of the externalizing disorders was equal to that of the subjectively severe form of the internalizing disorders. That is to say, therapist trainees viewed externalizing behaviors, overall, as more difficult to treat than internalizing behaviors. Clients with internalizing



disorders—even severe ones—while difficult to work with, may be viewed as less so than externalizing disorders.

The average level of PSD in response to each vignette illustrates the potential impact that PSD may have on therapist trainees. To measure PSD, therapist trainees rated each item on a scale of 0 (*none-at-all*) to 5 (*completely*), with higher scores indicating more PSD. Remarkably, the only vignette associated with PSD levels above the midpoint of 2.5 was that which portrayed the adolescent boy with CD-Severe. This finding further confirms the hypothesis that unmotivated, violent, aggressive, and high-stakes clients influence therapists' PSD.

In that sense, therapist trainees expressed relatively low PSD for each of the included disorders, with the exception of CD-Severe. The relatively low values of PSD for these disorders may be indicative of the therapist trainees' naiveté regarding the extant literature on treatment success rates. For instance, OCD is a particularly difficult disorder to treat, with recovery status being achieved for only 58-67% of treatment completers (Whittal, Thordarson, & McLean, 2005). Alternatively, 76% of individuals with SAD achieved clinically significant improvement after receiving evidence-based treatment (Clark et al., 2003, 2006). The current study, nonetheless, did not examine therapist trainees' responses to PSD. Targets for such responses are discussed in later sections.

These findings can be better understood by the ways in which therapist characteristics related to their expression of PSD in response to the vignettes. The data supported the hypothesis that therapist trainees' perspective taking would positively

correlate with estimate of overall PSD. In other words, therapist trainees were less likely to feel ineffective or incompetent when they could better adopt the perspective of the clients. Overall, this discovery suggests that understanding clients' viewpoints is important when evaluating one's own ability to help them.

Indeed, the prior research supports this concept. Empathy is characterized by both affective and cognitive factors (Greenberg, Rice, & Elliot, 1993). Whereas affective understanding may influence the therapeutic bond, cognitive and experiential understanding may influence self-exploration and restructuring processes (Bohart & Greenberg, 1997). In relation to PSD, adopting the perspective of another person seems important in defining one's ability to help them. Perhaps those who are more geared toward adopting the cognitive perspective of another can use this understanding to support their sense of effectiveness.

Although the cognitive source of empathy was significantly correlated with the estimate of overall PSD, affective empathy was not. Contrary to the hypothesis, therapist trainees' empathic concern was not related to their overall PSD. To better understand the lack of relation between the constructs, we performed exploratory analyses using Pearson's correlation coefficient for therapist trainees' empathic concern and each of the four PSD values. The only PSD value to correlate with empathic concern was associated with the vignette portraying CD-Severe. This finding is likely best explained through two related notions. First, because neither the estimate of overall PSD nor the counselor activity self-efficacy scale (CASES) significantly correlated with empathic concern, it is likely that therapist trainees' ability to experience empathy is unrelated to their sense of

doubt or confidence in therapy settings. In fact, one study using the CASES and IRI reported that empathic concern did not significantly predict therapist trainees' self-efficacy (Greason & Cashwell, 2009). Another study suggested that empathy in a therapeutic setting may differ from that in a social setting, which the IRI focuses (Barrett-Lennard, 1981). Therapist trainees may respond differently in a therapy setting than they do in a non-specific, social setting.

Second, qualitative research posits that novice therapists may experience greatest PSD when working with clients who violate their moral values (Thériault & Gazzola, 2010). Because the only PSD scores to correlate with empathic concern was CD-Severe, therapist trainees may experience greater PSD because they are empathizing—not with the clients—with the clients' victims. Individuals with CD, by definition, violate others' rights (APA, 2013). Therapist trainees who work with clients who have victimized others may feel vicariously violated (Thériault & Gazzola, 2010). Research on therapist reactions to working with sex offenders helps explain this phenomenon. In one study, over 50% of therapists who worked with sexual offenders reported clinically significant trauma reactions through vicarious traumatization—empathizing the trauma experience of another (Way, VanDeusen, Martin, Applegate, & Jandle, 2004). Large proportions of therapists appear to have considerable difficulty working with clients who have victimized others, particularly those who were perpetrators of sexual aggression (Moulden & Firestone, 2007). As a comparison, the current study examined PSD in response to an adolescent boy who expressed no remorse for cruelty to animals, multiple violent assaults, destruction of others' property, and arson. These findings, interpreted

alongside the extant research, support the concept that therapist trainees' find difficulty in working with those who act in ways that are contrary to their morals.

As previously mentioned, hypothesis testing included analyses to determine both client and therapist characteristics that might influence PSD, to better understand its sources and potential clinical utility. Additional testing was performed to test the discriminant validity with a conceptually related tool used within the field of developing therapists (Lent et al., 2003). Specifically, CASES is a construct that is conceptually inverse to PSD, considering it is a measure of one's confidence in their ability rather than doubt. It was hypothesized that PSD would negatively correlate with both subscales of the CASES. Results indicated that the hypothesis was supported. In fact, subscales of the CASES yielded medium sized, negative correlations with the overall estimate of PSD. The shared variance between the two measures suggests their overlapping predictive power. Because the relation between the constructs was only a medium, yet negative correlation, there is evidence that the instruments possess unique contribution in measuring opposing constructs. These correlations demonstrate discriminant validity of PSD with the CASES. Simply put, PSD and self-efficacy are related, yet distinct concepts.

After hypothesis testing was completed, exploratory analyses were performed to better understand PSD in relation to therapist trainees' characteristics. It is important to consider the characteristics when making judgements and interpretations. Of note, the current sample was largely composed of women (83.6%). This proportion raises important considerations for the generalization of the findings. First, therapists and

clients of the same gender often witness more success in therapy process (e.g., higher therapeutic alliance) and outcome (e.g., completing treatment; Wintersteen, Mensinger, & Diamond, 2005). It is possible that, because the clients within the vignettes were boys, therapist trainees' expression of PSD may be unduly influenced by a gender "mismatch." The importance of client and therapist gender match on therapy process and outcome, however, is debated. Some studies find that the gender dyads are influential (e.g., Wintersteen et al., 2005), whereas others do not (e.g., Jones & Zoppel, 1982). Whether or not therapist trainees' PSD is impacted by the mismatch in therapist-client gender, the results of this study are most generalizable to therapist trainees who identify as women.

With such a large proportion of the sample being women alongside evidence that gender matching in therapy influences therapy process, one concern is that men influenced the main findings. To answer this question, an exploratory analysis was conducted in which therapist trainees who identified as men (13.8%) were excluded from analyses; there was insufficient power to test the primary hypothesis with men, alone. Rerunning the repeated measures ANOVA with women only yielded results similar to that found in the larger sample which included participants of all genders. Thus, these results hold for women; although, more research is needed to understand the effects on men.

Another concern, therapist trainees within this sample were at various levels of graduate training (e.g., first, second, third year). Some of those included in the sample may already have experience working with clients, which could be potentially influential in their sense of doubt or confidence within treatment contexts. Differences in PSD

across vignettes were examined for those who *had* and *had not* started seeing clients. Because prior research notes that level of experience in therapy influences expression of PSD, with more experienced therapists expressing less PSD (Skovholt & Rønnestad, 2003), it was posited that therapist trainees' who are seeing clients may express less PSD. Approximately 50% of the participants were, in fact, currently seeing clients ( $n = 34$ ). Whether therapist trainees were seeing clients did not affect the expression of PSD across vignettes. Namely, experience in a therapy context, at least at the early stages of training, does not affect the level of expressed PSD. Although Skovholt and Rønnestad (2003) found that therapists' experience determined the amount of PSD, they measured experience in terms of multiple years. The attenuation of PSD over time may be a factor of years rather than a shorter time-frame (e.g., one year).

#### Clinical Implications

The results of this study suggest that PSD is significantly impacted by client characteristics. Overall, externalizing disorders generate greater PSD than do internalizing disorders in therapist trainees. Such a finding illustrates the importance of providing regular supervisory and feedback sessions for therapist trainees, particularly for those working with clients who are likely to violate the therapist trainees' moral values, such as those with CD. These findings serve to further justify PSD's inclusion as well as extend the recommendation that therapists maintain a disconfirmatory stance when appraising their effectiveness throughout their career (Beidas & Kendall, 2010; Tracey et al., 2014).

Despite there being statistically significant differences for therapist trainees' ratings of PSD between OCD and SAD, it is possible that this small difference does not render practical significance. Given this information, and until additional studies are performed, it may be prudent to focus self-appraisals and feedback on those who are working with clients who demonstrate severe externalizing behaviors. Nonetheless, therapists do not stop learning and improving their clinical abilities once their formal education is completed. It is advisable for therapists and supervisors to track therapist progress in various arenas (e.g., self-doubt, self-efficacy, client outcomes) to reliably foster continual improvements.

It is recommended that structured instruments for self-appraisal be used in clinical contexts to support more accurate understanding of therapist's ability. Therapist trainees' PSD is inversely related to self-efficacy, providing evidence that both may be useful as tools for feedback within supervising developing therapists. The inverse relation of PSD and self-efficacy provides additional evidence to PSD's usage in empirical studies. Understanding the psychometric properties of such a tool can be beneficial in both the research and applied contexts. For instance, within applied contexts, PSD may be used in tandem with self-efficacy to understand the contribution of both factors on therapist trainees' performance and development. It is important to not only examine the factors that are influencing a sense of confidence, but also a sense of doubt. In fact, recent recommendations, previously alluded to, suggest that therapists maintain a disconfirmatory rather than confirmatory approach to their own ability in the therapy

context (Tracey et al., 2014). Actively seeking areas in which therapists are wrong may result in finding areas in which to improve.

In fact, some treatment programs organize regular individual and group feedback sessions to address self- and other-identified factors that may impede the progress of therapy (e.g., self-doubt) when working with clients with externalizing disorders. For example, multisystemic therapy (MST©) for antisocial behavior in children and adolescents represents a model for such programs (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009). Within the MST model, therapists attend required weekly feedback sessions at both individual and group levels, in which trained supervisors address therapist's concerns related to treatment barriers. Because working with children and adolescents who display externalizing disorders can be extremely challenging for the therapist, this structure serves to overcome the limitations of self-appraisal and provides unique ability to modify therapists' approaches to better suit the clients' needs. Given our findings, PSD may be a standardized instrument in which MST© therapists can overcome the potential inaccuracy of unguided self-appraisal (Walfish et al., 2012).

Further, therapist characteristics significantly impact the expression of PSD, both overall as well as in response to various disorder-types and levels of severity. The relation between CD-Severe and therapist trainees' empathic concern illustrate interesting implications. Therapist trainees' who are more empathic may find it more difficult to work with clients who have engaged in violent, aggressive, and destructive behaviors as well as those who show little remorse for their actions. As a result, it is prudent to



consider the impact that working with said populations may have on the developing therapist. Because burnout is unduly high among therapists who experience PSD (Guy, 2000), as well as those working with challenging populations (e.g., sex offenders; Moulden & Firestone, 2007), working early on to overcome PSD may prove beneficial to not only the client but also the therapist. Accurate self-appraisal as well as the aforementioned structured feedback may provide insight into ways in which the barrier may be resolved. Therapists' empathy for their clients is an important factor in facilitating positive outcomes (Bohart et al., 2002); therefore, methods of overcoming therapists' difficulty in generating empathy may prove helpful. It is important for both supervisors and trainees to consider the trainees' experience within the therapy context to facilitate improvements. Rønnestad and colleagues (2018) provide methods for supervisors to aid in the development of therapist trainees at various levels of experience. Consideration of their paradigm may be the most evidence-based route in overcoming the presence of PSD when working with clients who demonstrate externalizing behaviors which may violate therapists' moral values.

Therapist trainees' empathy has a role in generating aspects of their self-doubt, particularly when working with those with severe externalizing behaviors. However, adopting another's perspective may serve to overcome this limitation. Therapist trainees' ability to adopt the perspective of another appears to negatively correlate with their expression of PSD. Their understanding of clients' viewpoints, in other words, impacts the self-assessments of their ability to help them. As such, therapist trainees' perspective taking may be used to overcome their self-doubt when working with clients who would

otherwise be difficult to empathize with. For example, one method may be to find common experiential reference points between therapist and client to foster greater empathy (Hatcher et al., 2005). This method is particularly important when working with clients who may violate the morals of the therapist. In other words, because therapist trainees' perspective taking is negatively related to PSD, it may serve as a tool for overcoming PSD. Further research is required to test the notion, however.

#### Limitations and Future Directions

Several limitations in this study's development, implementation, and generalizability should be considered when interpreting its results. First, the sample may not be representative of the population. To obtain the current sample of 67 therapist trainees, 160 graduate coordinators were contacted to forward the survey to their students. This response rate is incredibly low given the number of contacted programs. For instance, if each program had even 20 graduate-level students who were eligible for inclusion in the study, then the response rate would be 2% of the potential 3,200 available students. Because 94 participants responded, with only 67 completing the survey, the graduate coordinators and subsequent therapist trainees may possess characteristics that are unrepresentative of the population. For example, those who responded may be more conscientious—taking time out of their busy schedules. Additionally, those who responded may be more empathic, particularly toward graduate-level researchers. In fact, comments to the survey illustrate positive support for graduate-level researchers taking time to examine a phenomenon that they, as graduate-level clinicians, experience. Different sampling methods, other than email, may be used to contact graduate

coordinators as well as therapist trainees for similar projects in the future. Potential methods may include directly contacting students whose email addresses are available on the programs' websites, calling graduate coordinators directly to discuss distributions of the surveys, and utilizing local graduate programs to recruit therapist trainees in person.

A second concern is that the current study examined PSD in response to a limited number of client characteristics. Only four, specific manifestations of mental illness were included in this study. As there are countless forms of mental illness, in terms of comorbidities and impairment, this study provides only a limited view into the relation between PSD and mental illness. However, little research existed prior to this study regarding the relation between PSD and client characteristics. As a result, this study may serve as a benchmark from which additional research on this topic can be developed. For example, future research may add other client characteristics described by Thériault and Gazzola (2010) which are dissimilar to those within the current study (e.g., psychotic, suicidal).

Similarly, the only client characteristics examined within this study involved mental illness. Client characteristics within the vignettes, other than presenting problem, were matched to increase internal validity. Nonetheless, a multitude of client variables (e.g., gender, age, ethnicity, personality) may impact therapist responses in treatment (Constantino et al., 2011; Wisch & Mahalik, 1999). Most therapist trainees within the sample (>80%), in fact, were primarily interested in working with adult clients with internalizing problems (e.g., PTSD, depression). Given that the client characteristics represent a population in which therapist trainees were neither experienced nor interested

(i.e., adolescent boys with CD), PSD may be unduly impacted. Future research should include larger samples of therapist trainees as well as those interested in a greater variety of client populations.

A third concern, therapist characteristics within this sample limit the generalizability of its findings. Participants were largely in their early 20s, white, and women. Whereas this population may represent a large proportion of those who provide therapy, additional research is required before generalizations can be made. Future studies, for instance, may design stratified random samples of therapists across the United States using the factors of gender, age, race/ethnicity, and client population of interest. In fact, such a study may better serve the understanding of PSD's relation to therapist characteristics, given that little is known about which characteristics are predictive of greater/lesser PSD.

A fourth concern, the wording of the PSD scales and CASES neglected to account for therapist trainees' predictions of client outcomes. The items were worded in order to understand how therapist trainees' view therapy process rather than therapy outcome. That is to say, the scales measured how therapist trainees' may react within the session (e.g., lose control of the therapeutic situation). As such, therapist trainees' may believe that they are not capable of adapting to the demands of the therapy process, yet still believe they are effective in terms of therapy outcomes. Future research may examine adaptations of both the PSD scale and CASES to understand the relation between therapist trainees' belief in their ability to engage successful therapy process and facilitate successful therapy outcome.

A fifth concern, the scale used to measure empathic concern (i.e., Interpersonal Reactivity Index; Davis, 1983), is likely not the best tool for determining empathy in a therapeutic context. Interpretations of the items illustrate emotional reactivity to given situations in a social context (e.g., “other peoples’ misfortunes do not disturb me a great deal”) rather than overall affective empathy. Observer-rater scales for therapist empathy may include more appropriate terminology given the purposes of this study. For example, the Therapist Empathy Scale contains nine items that provide detailed descriptions of therapists’ moment-to-moment expressions of empathy (Decker, Nich, Carroll, & Martino, 2014). Future research may examine therapist trainees’ self-doubt in relation to working with clients *in vivo*, with added observer ratings of therapist empathy.

Finally, due to the relatively low values for PSD in response to each vignette, aside from those in response to the CD-Severe vignette, it is important to consider the potential impact of *over-confidence* in ones’ ability to facilitate client change. Certainly, PSD may be helpful when examining oneself for self-improvement (Nissen-Lie et al., 2017); however, there are important implications to consider for those who are not critical of themselves in the therapeutic context. Because the inaccuracy of self-appraisals is related to worse outcomes (Tracey et al., 2014), it is likely that those who are over-confident may be harmful to their clients (e.g., clients’ deterioration, drop-out, non-improvement). Examining the accuracy of therapist trainees’ self-assessments regarding PSD is beyond the scope of this study. Nonetheless, future research may consider third-party observations, such as supervisors, to provide a cross-reference to therapist trainees’ self-appraisals in the quest to determine the best-practice methods.

### Overall Conclusions

This is the first known study which examined the relation between client characteristics and the expression of PSD among therapist trainees. Therapist trainees expressed greatest PSD when working with clients who exhibit CD-Severe, followed by OCD and CD-Mild equally, and finally SAD. Overall, clients with externalizing disorders elicit the greatest PSD among therapist trainees. These differences may be, in part, explained by therapist trainees' empathic concern for the victims of clients with severe externalizing disorders. Supervisors as well as therapist trainees may use evidence-based methods as well as informative recommendations from scholars to intentionally address and overcome the effects that PSD can have on both the client and the therapist (Rønnestad et al., 2018; Tracey et al., 2014). Programs that integrate regular feedback for therapists to continue developing expertise are likely to be most beneficial in addressing the negative outcomes related to PSD, particularly for those working with clients with severe externalizing disorders.

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## APPENDIX A

*DSM-5* Conduct Disorder Symptoms (APA, 2013, pp. 469-471)

## Criterion A: Behavior

## Aggression

1. Often bullies, threatens, or intimidates others.
2. Often initiates physical fights.
3. Has used a weapon that can cause serious physical harm to others (e., a bat, brick, broken bottle, knife, gun).
4. Has been physically cruel to people.
5. Has been physically cruel to animals.
6. Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery).
7. Has forced someone into sexual activity.

## Destruction to Property

8. Has deliberately engaged in fire setting with the intention of causing serious damage.
9. Has deliberately destroyed others' property (other than by fire setting).

## Deceitfulness or Theft

10. Has broken into someone else's house, building, or car.
11. Often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others).
12. Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery).



### Serious Violations of Rules

13. Often stays out at night despite parental prohibitions, beginning before age 13 years.
14. Has run away from home overnight at least twice while living in the parental or parental surrogate home, or once without returning for a lengthy period.
15. Is often truant from school, beginning before age 13 years.

### Criterion B: Impairment

The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

### Criterion C: Exclusion

If the individual is age 18 years or older, criteria are not met for antisocial personality disorder.

#### Specify if: Childhood-onset type

Individuals show at least one symptom characteristic of CD prior to age 10 years.

#### Specify if: Adolescent-onset type

Individuals show no symptoms characteristic of CD prior to age 10 years.

#### Specify if: Unspecified onset

Criteria for a diagnosis of CD are met, but there is not enough information available to determine whether the onset of the first symptom was before or after age 10 years.

## APPENDIX B

*Vignette 1*

A boy named Michael 14 years of age, has shown various types of behavior typical for conduct disorder in the past. He is physically cruel to animals. Also, he was arrested two times for assault. He has deliberately destroyed others' property by setting it on fire. Four months ago, he broke into a convenience store. When asked, he states that he does not feel guilty for the things he has done. When punished, he takes no interest in changing his behaviors.

*Vignette 2*

A boy named Jacob, 14 years of age, has shown various types of behavior typical for conduct disorder in the past. He has been caught skipping school. He often steals items from people when they are not looking. Four months ago, he ran away from home and stayed away for four days. He has poor performance at school. He often stays out at night, despite his parents' prohibition of the behavior. When punished, he states feeling guilty for committing wrongs.

*Vignette 3*

A boy named Joshua, 14 years of age, has shown various types of behavior typical for obsessive compulsive disorder. He has recurrent and persistent thoughts that his parents will die. He cleans objects repeatedly. In the past 6 months, he has been caught cleaning and organizing the garbage. Four months ago, he washed the carpet for more than four hours, causing his hands to dry and bleed. In conversation, it is apparent that Joshua is convinced his parents will die if he does not follow-through with his compulsions.

*Vignette 4*

A boy named Matthew, 14 years of age, has shown various types of behavior typical for social anxiety disorder. He experiences intense fear and anxiety of social situations. He often avoids any interaction with others at school. He has been reported saying that he fears he will be humiliated by others. Four months ago, he made became worked up when he was home alone, and a neighbor knocked on the door. He almost always avoids any social interaction unless with immediate family members.

## APPENDIX C

Professional Self-Doubt (PSD; Orlinsky & Rønnestad, 2005)

*Please indicate, in the following items, how you might feel in response to treating the child in the previous paragraph. With (0) indicating “none-at-all” and (5) indicating “completely”.*

1. Lacking in confidence that you might have a beneficial effect on [insert name]
2. Unsure how best to deal effectively with [insert name]
3. Distressed by powerlessness to affect [insert name] tragic life situation
4. Disturbed that circumstances in your private life will interfere with your work
5. In danger of losing control of the therapeutic situation with [insert name]
6. Afraid that you are doing more harm than good in treating [insert name]
7. Demoralized by your inability to find ways to help [insert name]
8. Unable to generate sufficient momentum with [insert name]
9. Unable to comprehend the essence of [insert name] problem

## APPENDIX D

## Interpersonal Reactivity Index (IRI; Davis, 1983)

*The following statements inquire about your thoughts and feelings in a variety of situations. For each item, indicate how well it describes you by choosing the appropriate letter on the scale at the top of the page: A, B, C, D, or E. When you have decided on your answer, fill in the letter next to the item number. READ EACH ITEM CAREFULLY BEFORE RESPONDING. Answer as honestly as you can. Thank you.*

## ANSWER SCALE:

A (Does not describe me well)—B—C—D—E (Describes me very well)

1. I daydream and fantasize, with some regularity, about things that might happen to me. (FS)
2. I often have tender, concerned feelings for people less fortunate than me. (EC)
3. I sometimes find it difficult to see things from the "other guy's" point of view. (PT) (-)
4. Sometimes I don't feel very sorry for other people when they are having problems. (EC) (-)
5. I really get involved with the feelings of the characters in a novel. (FS)
6. In emergency situations, I feel apprehensive and ill-at-ease. (PD)
7. I am usually objective when I watch a movie or play, and I don't often get completely caught up in it. (FS) (-)
8. I try to look at everybody's side of a disagreement before I make a decision. (PT)
9. When I see someone being taken advantage of, I feel kind of protective towards them. (EC)
10. I sometimes feel helpless when I am in the middle of a very emotional situation. (PD)
11. I sometimes try to understand my friends better by imagining how things look from their perspective. (PT)
- Becoming extremely involved in a good book or movie is somewhat rare for me. (FS) (-)
13. When I see someone get hurt, I tend to remain calm. (PD) (-)

14. Other people's misfortunes do not usually disturb me a great deal. (EC) (-)
15. If I'm sure I'm right about something, I don't waste much time listening to other people's arguments. (PT) (-)
16. After seeing a play or movie, I have felt as though I were one of the characters. (FS)
17. Being in a tense emotional situation scares me. (PD)
18. When I see someone being treated unfairly, I sometimes don't feel very much pity for them. (EC) (-)
19. I am usually pretty effective in dealing with emergencies. (PD) (-)
20. I am often quite touched by things that I see happen. (EC)
21. I believe that there are two sides to every question and try to look at them both. (PT)
22. I would describe myself as a pretty soft-hearted person. (EC)
23. When I watch a good movie, I can very easily put myself in the place of a leading character. (FS)
24. I tend to lose control during emergencies. (PD)
25. When I'm upset at someone, I usually try to "put myself in his shoes" for a while. (PT)
26. When I am reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me. (FS)
27. When I see someone who badly needs help in an emergency, I go to pieces. (PD)
28. Before criticizing somebody, I try to imagine how I would feel if I were in their place. (PT)

Scoring:

NOTE: (-) denotes item to be scored in reverse fashion PT = perspective-taking scale  
FS = fantasy scale EC = empathic concern scale PD = personal distress scale

## APPENDIX E

Counselor Activity Self-Efficacy Scale (CASES; Lent, Hill, & Hoffman, 2003)

Session Management Self-Efficacy Items

*Please indicate how confident you are in your ability to do each of the following tasks effectively, over the next week, in counseling most clients. Use the following options, no confidence (0) to complete confidence (9).*

1. Help your client to understand his or her thoughts, feelings, and actions.
2. Know what to do or say next after your client talks.
3. Help your client to talk about his or her concerns at a deep level.
4. Build a clear conceptualization of your client and his or her counseling issues.
5. Help your client to explore his or her thoughts, feelings, and actions.
6. Respond with the best helping skill, depending on what your client needs at a given moment.
7. Help your client to set realistic counseling goals.
8. Keep sessions on track and focused.
9. Remain aware of your intentions (i.e., the purposes of your interventions) during sessions.
10. Help your client to decide what actions to take regarding his or her problems.

## Counseling Challenges Self-Efficacy Items

*Indicate how confident you are in your ability to work effectively, over the next week, with each of the following client types, issues, or scenarios. (By “work effectively” we are referring to your ability to develop successful treatment plans, to come up with polished in session responses, to maintain your poise during difficult interactions and, ultimately, to help the client to resolve his or her issues.) Use the following options, no confidence (0) to complete confidence (9).*

***How confident are you that you could work effectively over the next week with a client who...***

1. Relationship Conflict
  - a. ...you have negative reactions toward (e.g., boredom, annoyance).
  - b. ...is at an impasse in therapy.
  - c. ...wants more from you than you are willing to give (e.g., in terms of frequency of contacts or problem-solving prescriptions)
  - d. ...is dealing with issues that you personally find difficult to handle.
  - e. ...demonstrates manipulative behaviors in session.
  - f. ...is not psychologically minded or introspective.
  - g. ...is sexually attracted to you.
  - h. ...you find sexually attractive.
  - i. ...differs from you in a major way or ways (e.g., race, ethnicity, gender, age, social class).
  - j. ...has core values or beliefs that conflict with your own (e.g., regarding religion, gender roles).
2. Client Distress
  - a. ...has experienced a recent traumatic life event (e.g., physical or psychological injury or abuse).
  - b. ...has been sexually abused.
  - c. ...is clinically depressed.
  - d. ...is suicidal.
  - e. ...is extremely anxious.
  - f. ...shows signs of severely disturbed thinking.



## APPENDIX F

**Demographics**

1. Gender

Male      Female      Transgender Male      Transgender Female      Not  
Listed

2. Age (in years): \_\_\_\_\_

3. Race/ethnicity (check all that apply):

African American/Black      Asian American      Caucasian/White  
Latino/Latina/Hispanic      Native American      Other \_\_\_\_\_

4. Please rate the quality of your performance as a therapist relative to your  
colleagues. Check one:

Bottom 10%      Bottom 25%      Average      Top 75%      Top 10%

5. Please indicate the number of hours of experience you have in therapy directly  
with clients: \_\_\_\_\_

6. Please indicate the number of hours of experience you have in therapy directly  
with clients who present with the following disorders:

Obsessive-Compulsive Disorder: \_\_\_\_\_

Conduct Disorder: \_\_\_\_\_

Social Anxiety Disorder: \_\_\_\_\_

7. What is your theoretical orientation? \_\_\_\_\_

8. What are your typical therapeutic interventions? You may indicate more than one.

\_\_\_\_\_

9. Please indicate your area of interest. For instance, if you are interested in working specifically with individuals with depression. \_\_\_\_\_

**Attention Checks**

1. Please select the option labeled “Three”? Check one:

One            Three            Four            Six

2. Please type the word “bat” in the space provided below.

\_\_\_\_\_

**Treatment Difficulty**

Please indicate on a scale of 1 (*easy*) to 5 (*impossible*), how difficult you may find it to treat this child.

1            2            3            4            5

## APPENDIX G

### **Informed Consent Document**

Project Title: **Therapist Self-Doubt When Facing Severe Psychopathology in Adolescent Males**

Graduate Student Researcher: **Zachary Meehan**

Institution: **University of Northern Iowa**

Faculty Supervisor: **Dr. Elizabeth Lefler, Department of Psychology**

#### **WHAT IS THE PURPOSE OF THIS STUDY?**

You are being invited to take part in research designed to clarify personal and environmental predictors of counselors' confidence. Our research may help improve theories of the success of developing expertise in therapy.

#### **WHAT IS THE PURPOSE OF THIS FORM?**

This consent form gives you the information you will need to help you decide whether to be in the study or not. Please read the form carefully. You may ask any questions about the research, the possible risks and benefits, your rights as a volunteer, and anything else that is not clear (researcher contact information is at the end of this form).

#### **WHY AM I BEING INVITED TO TAKE PART IN THIS STUDY?**

You are being invited to take part in this study because you are a master's level student currently enrolled in a counseling psychology program in the United States. You must be 18 years or older to consent.

#### **WHAT WILL HAPPEN DURING THIS STUDY AND HOW LONG WILL IT TAKE?**

You will read four vignettes depicting adolescent boys with various mental illnesses. After each vignette you will respond to a scale inquiring about your perceptions of said vignette. Once you've completed all four vignettes and associated scales, you will complete a survey designed to measure empathy. Next, you will complete a survey designed to measure your perceptions of your own self-efficacy (AKA confidence) in various aspects of counseling. Last, you will complete a short demographics questionnaire. The entire experiment will take you approximately 10 minutes to complete.

#### **WHAT ARE THE RISKS OF THIS STUDY?**

There are no foreseeable risks and/or discomforts associated with the procedures described.

#### **WHAT ARE THE BENEFITS OF THIS STUDY?**

We do not know if you will benefit from being in this study. The field may benefit from learning about professional confidence in counselors.

### **WILL I BE PAID FOR PARTICIPATING?**

You will be provided with \$8 compensation in the form of a prepaid debit card upon completion of the study. On the final page of the online survey, there will be a link to a document collecting your email address. Following data collection, the graduate researcher will send you an email containing a link to your prepaid card as well as a copy of the consent and debrief forms.

### **WHO WILL SEE THE INFORMATION I GIVE?**

Confidentiality will be maintained to the degree permitted by the technology used. No guarantees can be made regarding the interception of data via third parties. The information you provide during this research study will be kept confidential to the extent permitted by law. Data will be stored on securely password-protected computers and in locked offices. Only researchers involved in this project will have access to the data files. If the results of this project are published, your identity will not be made public. Data will be stored securely for seven years after any resulting presentation or publication, in accordance with the standards of the American Psychological Association. After that time, electronic files will be deleted if continued secure storage is problematic.

### **DO I HAVE A CHOICE TO BE IN THE STUDY?**

If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any benefits or rights you would normally have if you choose not to volunteer. You can stop at any time during the study and keep the benefits and rights you had before volunteering. You will not be treated differently if you decide to stop taking part in the study. If you feel uncomfortable answering any of the questionnaire items, you may feel free to stop at any time.

### **WHAT IF I HAVE QUESTIONS?**

If you have any questions about this research project, please contact the faculty supervisor, Dr. Elizabeth Lefler ([elizabeth.lefler@uni.edu](mailto:elizabeth.lefler@uni.edu), telephone (319)-273-7637), or ask the graduate researcher, Zachary Meehan ([meehanz@uni.edu](mailto:meehanz@uni.edu), telephone (660)-349-7224). If you have questions about your rights as a participant, please contact the University of Northern Iowa's Institutional Review Board Administrator Anita Gordon, Director of Research Ethics ([anita.gordon@uni.edu](mailto:anita.gordon@uni.edu), telephone (319)-273-6148).

Your signature (by checking the box below) indicates that you are at least 18 years of age, this research study has been explained to you, that your questions have been answered, that you agree to take part in this study and understand that your participation is voluntary, and that you may withdraw at any time.