



# Therapist Experience, Personal Therapy, and Distressing States of Mind: Regulation and Resonance as Dialectics of Therapeutic Empathy

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## Abstract

The current study is based on the notion of an empathic dialectic, marked by states of emotional resonance and regulation, which has been described by contemporary theories of therapeutic empathy and empirically supported by research on non-therapists. We operationalized emotional resonance as personal distress empathy, and we sought to examine how activities promoting self-regulation impact the association between personal distress empathy, and other facets of poor self-regulation. This was accomplished through an online study, which administered several self-report instruments to a sample of 158 non-therapists and 139 therapists of various levels of experience, collecting participants' demographic information, attachment status, level of shame-proneness, the fear of invalidity, and personal distress empathy. We examined the impact of several moderators on the paths from attachment anxiety, shame-proneness, and the fear of invalidity to personal distress empathy; and, thus, on the indirect effect between attachment anxiety and personal distress empathy. For our first hypothesis, we expected therapist status to significantly moderate the paths in this proposed meditation. For our second hypothesis, we anticipated personal therapy sessions would significantly moderate this meditation. For our third hypothesis, we expected that both personal therapy *and* therapist experience level would moderate this mediation. Most notably, our results indicated that the fear of invalidity explained the association between attachment anxiety and personal distress empathy, and this mediation was stronger among non-therapists when compared to therapists. Yet, personal therapy did not similarly impact the relationships among these variables. Implications for future research are discussed.

**Keywords** Attachment · Empathic process · Personal distress empathy · Therapist effects · Therapist training · Therapist supervision

Research spanning over the last four decades has established therapeutic empathy as a key common factor predicting psychotherapy outcome (e.g., Elliot et al. 2018; Wampold and Imel 2015), and recent research suggests it may be particularly influential in the early phase of treatment (McClintock et al. 2018). Despite the importance of therapeutic empathy,

the diverse ways it has been defined, starting with Kohut (1959) and Rogers (1959), poses a challenge in establishing a standardized definition of this construct. Psychotherapy researchers tend to endorse static and unidimensional definitions of therapeutic empathy (e.g., Hall et al. 2012), though social neuroscientists have validated the multidimensional nature of empathy among non-therapists (e.g., Decety and Lamm 2009), and theorists have long referred to therapeutic empathy as a complex process (e.g., Rogers 1975). Similarly embracing its complexity, we refer to an empathic dialectic, marked by the therapist's capacity to "feel into" the patient's emotional experience and "feel out of" such states by regaining emotional balance (Buechler 2008). In the current study, we examine this dialectic by investigating how activities promoting self-regulation (i.e., therapist experience and/or personal therapy) influence facets of poor self-regulation (i.e., attachment anxiety, shame-proneness, the fear of invalidity,

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and personal distress empathy), in a sample of non-therapists and therapists of all levels of experience.

## Therapeutic Empathy

### Trait Empathy

Researchers commonly investigate empathy utilizing a trait measure called the Interpersonal Reactivity Index (IRI; Davis 1983), which describes four dimensions of interpersonal reactivity, including two that are considered cognitive (i.e., fantasy, and perspective taking), and two that are considered affective (i.e., empathic concern and personal distress empathy). Focusing on the affective dimensions, Batson et al. (1987) described empathic concern, or feelings of warmth and compassion for others, as stemming from an “other-oriented” motivation to reduce another’s need; whereas, they described personal distress empathy, or feelings of discomfort when faced with the emotions of others, as a “self-oriented” motivation to reduce one’s own need. Psychotherapy research comparing therapists to non-therapists, has found that therapists are more likely to endorse empathic concern (Hall et al. 2012) and less likely to endorse personal distress empathy (e.g., Hassenstab et al. 2007). Hassenstab et al. reasoned that personal distress empathy is less common among therapists because they are better able to regulate their distress; and, subsequent research has found that therapists more effectively down-regulate negative emotions (Pletzer et al. 2015). Perhaps for this reason, psychotherapy researchers appear only to have examined and validated the relationship between personal distress empathy and burnout among medical professionals (Fülöp et al. 2011; Karyagina et al. 2017), and those that refer to the empathic process have not considered therapists’ personal distress empathy (Hatcher et al. 2005).

### The Empathic Dialectic

Akin to theories that allude to a therapeutic empathic process (e.g., Buechler 2008; Ehrenberg 1992; Holmes and Slade 2018), social neuroscience research suggests that empathy is best defined as a multidimensional phenomenon, which may include traits like personal distress empathy. After reviewing studies that have used functional magnetic resonance imaging (fMRI) to measure empathy in non-therapists, Decety and Lamm (2009) argue that several discrete neural networks are involved in empathizing with another’s pain. These networks include those linked to automatic self-oriented processes marked by emotional contagion (e.g., personal distress empathy) and those linked to deliberate other-oriented processes marked by perspective taking (e.g., empathic concern). Decety and Lamm (2009)

further contend, however, that self-regulation is *required* to tone down self-oriented states of distress, such that one can effectively adopt an other-oriented perspective: and, indeed, psychotherapy research suggests therapeutic empathy is enhanced by self-regulatory activities (i.e., mindfulness) (Davis and Hayes 2011).

### Attachment Theory

The self-regulation required for empathy has been found, by social neuroscience research, to *originate* in one’s childhood attachment relationships (Tucker et al. 2005). Those with secure childhood attachment tend to internalize representations of significant others as sensitive and available, and—due to their brain’s associated capacity to self-regulate and *co*-regulate what could otherwise be too emotionally overwhelming (Porges 2011) and subsequent empathy (Mikulincer et al. 2001)—they often become caregivers who are similarly sensitive and available (Main et al. 2005). Regulatory skills also help to explain how secure individuals provide “non-reciprocal feedback” (Dozier et al. 1994, p. 799), responding to their patients’ underlying emotional state and unmet needs (e.g., sadness about not feeling understood) rather than their defensive behavior (e.g., withdrawal). Perhaps for this reason, through their review of research on this topic, Obegi and Berant (2009) concluded that secure therapists’ sensitivity leads to exceptionally productive work.

### Attachment Anxiety

In direct contrast to attachment security and self-regulation, the current study focuses on attachment anxiety due to its association with *poor* self-regulation (i.e., poor interpersonal boundaries, emotional reactivity; and, diffuse/chaotic self and other experiences; Lopez 2001). Compared to secure or avoidant non-therapists, those with high levels of attachment anxiety tend to endorse high levels of personal distress empathy (Britton and Fuendeling 2005; Joireman et al. 2002), yet studies examining the impact of these traits on therapeutic empathy render mixed results. On one hand, Trusty et al. (2005) have found that student-counselors who endorse high levels of attachment anxiety tend to demonstrate heightened levels of emotional empathy, as defined by “heightened responsiveness to another’s emotional experience” (Mehrabian and Epstein 1972, p. 526). On the other hand, attachment anxiety negatively impacts other skills, like therapists’ capacity to address “ruptures,” which Safran (1993) defined as “negative shifts in the quality of the therapeutic alliance or ongoing problems in establishing one” (p. 34). This was found by Rubino et al. (2000), who presented 77 therapist trainees with a video of a patient experiencing a

rupture in the alliance, and then asked them to respond to the patient as if they were interacting with him or her in session. Observers rated the responses of therapists who had self-reported high levels of attachment anxiety as *less* empathic, when compared to those who had self-reported high levels of security or avoidance. Therapists with attachment anxiety may struggle to respond empathically to patients during ruptures, because they are prone to poor self-regulation; and, indeed, Marmarosh et al. (2015) has found that novice therapists who endorse high levels of attachment anxiety also tend to endorse more tension following perceived ruptures.

Research using samples of undergraduates has uncovered several traits that are associated with attachment anxiety and personal distress empathy, which further illustrate the dynamics that may underlie these moments of tension following ruptures. In studies using undergraduate samples, attachment anxiety has been associated with high levels of shame-proneness (Lopez et al. 1997), marked by the tendency toward “negative evaluation[s] of the whole self that emphasize internal, global, and uncontrollability attributions” (p. 189), and the fear of invalidity (Mikulincer et al. 2010), marked by “doubt and uncertainty about one’s understanding of events and experiences” (Lynch et al. 2012, p. 438). In other studies using similar samples, personal distress empathy has been linked to shame-proneness (Ranganathan and Todorov 2010), and the fear of invalidity (Lynch et al. 2012). The inter-relationships among attachment anxiety, shame-proneness, the fear of invalidity, and personal distress empathy are likely to reflect an underlying propensity toward poor self-regulation. As facets of poor self-regulation, these traits help to explain the empathic failures made by anxious therapist trainees during rupture events (Rubino et al. 2000). In the current study, we expect the negative self-evaluation inherent to shame-proneness and the fear of invalidity to explain the relationship between attachment anxiety and personal distress empathy. Since the aforementioned research was conducted on undergraduates (i.e., Lynch et al. 2012) or those with little therapist experience (Rubino et al. 2000), we expect our proposed mediation will be significant among non-therapists and those with low levels of therapist experience.

### Therapist Status, Therapist Experience Level, and Personal Therapy

Due to a lack of extant research on this topic, it remains unclear whether personal distress empathy can be harnessed into an adaptive trait that is relatively unassociated with other facets of poor self-regulation (i.e., attachment anxiety, shame-proneness, and the fear of invalidity), among those who regularly practice self-regulation as therapists and/or in personal therapy. Yet, it seems very likely that this would

be true. At the most basic level, the tendency to experience personal distress empathy in response to distressing stimuli is *positively* associated with pro-social behavior in older non-therapists (Sze et al. 2012). Beyond the impact of age, the literature suggests that therapist experience and personal therapy each enhance self-regulation. In terms of personal therapy, certain treatments (i.e., psychodynamic) have been shown to enhance one’s capacity to understand behavior (i.e., one’s own and others’) in terms of underlying mental states (Levy et al. 2006), thereby developing what Roisman et al. (2002) referred to as “earned security.” In terms of therapist experience level, research has shown that therapists’ anxiety lessens substantially over time (Rønnestad and Skovholt 2003). In terms of both therapist experience and personal therapy, therapists are more likely to seek out and benefit from personal therapy (Norcross 2005). Consistent with theories of the empathic process (e.g., Buechler 2008), therapist status, therapist experience, and personal therapy all seemingly enhance the self-regulation that would be required to use personal distress empathy in an adaptive, pro-social, manner.

The current study sought to investigate the conditions under which personal distress empathy represents an advantageous component of empathy, marked by emotional resonance, by examining the impact of self-regulatory activities (therapist experience and/or personal therapy) on its relationship to other facets of poor self-regulation (attachment anxiety, shame-proneness, the fear of invalidity). Using the full sample, we expected therapist status to moderate the effect of attachment anxiety, shame-proneness and the fear of invalidity on personal distress empathy; and, thus, the indirect effect between attachment anxiety and personal distress empathy. Next, we expected personal therapy to moderate the effect of attachment anxiety, shame-proneness and the fear of invalidity on personal distress empathy; and, thus, the indirect effect between attachment anxiety and personal distress empathy. Lastly, using only the sub-sample of therapists, we expected therapist experience *and* personal therapy to moderate this mediation.

## Method

### Participants

A total of 322 participants were recruited, yet some did not complete the protocol or were identified as outliers, resulting in a full sample of 297, including therapists ( $n=139$ ) and non-therapists ( $n=158$ ). Therapist-trainees were recruited from a college-counseling center within the greater New York City area, and practicing therapists were recruited through email notification to professional listservs. Non-therapists were recruited from undergraduate courses and

through fliers posted at the university. A pre-screening questionnaire was administered to determine each participant's eligibility. Therapists without at least one patient, or without a Master's or Doctorate degree, were excluded; non-therapists deemed "helping professionals" (e.g., Nurse, Doctor, or Minister) were also excluded. Demographic statistics for the sample, and descriptive statistics for the measures, are detailed on Table 1.

## Measures

### Attachment

The Relationship Scales Questionnaire (RSQ; Griffin and Bartholomew 1994) assessed attachment anxiety. The "attachment anxiety" subscale includes items like "I worry

about being abandoned," which participants are asked to rate on a scale from 1 (not at all like me) to 5 (very much like me). Based on a comparison of four models of attachment derived from the RSQ, Kurdek (2002) determined the model of best fit was uncovered in Simpson and colleagues' (1992) factor analysis, using a sample of 83 young adult couples. With regard to the attachment anxiety sub-scale, in the current study's full sample of therapists and non-therapists ( $N=297$ ), the Cronbach alpha ( $\alpha$ ) was .82.

### Shame-Proneness

The Test of Self-Conscious Affect-3 (TOSCA-3; Tangney et al. 2000) was used to assess shame-proneness. Sample items include scenarios, like "at work, you wait until the last minute to complete a project and it turns

**Table 1** Descriptive statistics

	Therapists %	Non-therapists %	$\chi^2$		
Gender	–	–	4.45		
Female	75.5	66.5	–		
Male	23.7	33.5	–		
Trans.	0.7	0.0	–		
Ethnicity	–	–	9.28		
Caucasian	76.3	62.0	–		
Asian <sup>a</sup>	5.0	7.6	–		
Indian <sup>b</sup>	3.6	7.6	–		
Black <sup>c</sup>	8.6	13.9	–		
Hispanic <sup>d</sup>	5.0	8.2	–		
Mixed	1.4	0.6	–		
	M (SD)	M (SD)	<i>t</i>		
Age	36.24 (11.69)	29.26 (13.67)	4.75***		
PT	306.3 (411.8)	117.5 (267.8)	4.62***		
	M (SD)	M (SD)	<i>t</i>	Skewness	Kurtosis
Preoccupied	10.91 (4.08)	12.90 (4.36)	4.05***	0.47	–0.35
Fear	51.05 (11.38)	52.20 (10.66)	0.90	–0.06	–0.01
Shame	32.77 (8.22)	32.92 (8.62)	0.15	–0.08	–0.22
PDE	18.70 (5.21)	16.01 (4.64)	4.67***	0.30	–0.17

Results presented as Full Sample ( $N=297$ ); Non-Therapist ( $n=158$ ); Therapist ( $n=139$ ); % and Mean are presented as they pertain to the total sample ( $N=297$ ); Results of *t* tests and Chi square ( $\chi^2$ ) tests detail group differences between the non-therapist and therapist groups

PT total number of personal therapy sessions, *Preoccupied* preoccupied attachment, *Fear* the fear of invalidity, *Shame* shame-proneness, *PDE* personal distress empathy

\* $p < .05$

\*\* $p < .01$

\*\*\* $p < .001$

<sup>a</sup>Asian = Asian American, Korean, Chinese, Filipino, Japanese, Vietnamese, Pacific Islander, Native Hawaiian, or Other Asian

<sup>b</sup>Indian = Asian Indian, American Indian, or Alaskan Native

<sup>c</sup>Black = African American, or Caribbean American

<sup>d</sup>Hispanic = Mexican, Puerto Rican, Cuban, or Other Hispanic

out badly,” and then rating the likelihood that (for example), “You would feel incompetent,” which participants are asked to rate on a scale ranging from 1 (not likely) to 5 (very likely). Previous research, using a sample of 150 undergraduates, confirmed the reliability of the shame-proneness subscale (Rangganadhan and Todorov 2010). For the full sample of 297 therapists and non-therapists in the current study,  $\alpha = .81$ .

### Fear of Invalidity

The Personal Fear of Invalidity Scale (PFIS; Thompson and Zanna 1995) assessed the fear of invalidity. Sample items include statements like, “I wish I didn’t worry so much about making errors,” which participants are instructed to rate on a scale ranging from 1 (strongly disagree) to 6 (strongly agree). Research has confirmed the reliability of the fear of invalidity scale, in a sample of 199 undergraduates (Lynch et al. 2012). For the full sample of therapists and non-therapists in the current study,  $\alpha = .83$ .

### Interpersonal Reactivity Index (IRI)

The IRI (Davis 1983)—a multidimensional self-report measure of trait empathy with subscales that measure fantasy, perspective taking, empathic concern, and personal distress empathy—was used to measure personal distress empathy. Sample items include statements like, “I sometimes feel helpless when I am in the middle of a very emotional situation,” which participants are instructed to rate on scale ranging from 0 (does not describe me well) to 5 (describes me very well). Research has confirmed the reliability of this subscale, using a sample of 290 psychologists (Hall et al. 2012). For the full sample of therapists and non-therapists in the current study,  $\alpha = .76$ .

### Therapist Status, Therapist Experience Level, and Personal Therapy

We asked participants to report the length of their therapist experience and/or personal therapy. “Therapist status” was determined by the participants’ endorsement of *any* amount of therapist experience over zero months. “Therapist experience level” was represented by the total number of months participants reported as a practicing therapist, and calculated by the reported number of years and/or months. “Personal therapy sessions” was represented by the total number of personal therapy sessions that participants endorsed attending therapy, and calculated by the reported number of years and/or months and sessions per week.

### Procedure

Participants completed the study online. The entire procedure required roughly 30 min and consisted of several questionnaires that were administered in the same order for every participant, including a pre-screening questionnaire, a consent form, a demographic questionnaire, the RSQ, the TOSCA-3, the PFIS, and the IRI. Researchers compensated student-participants with course credit, and non-helping professionals and therapists had the opportunity to enter a raffle (a \$200 Amazon Gift Card was rewarded to a randomly selected participant).

### Results

#### Data Analysis Plan

Preliminary analyses (described below) were conducted to prepare the dataset. Hypotheses were then tested in three separate models, using Hayes’ (2013) PROCESS macro for SPSS, which produced 95% bootstrap confidence intervals (CIs) from sampling and replacing 5000 samples to compute the indirect effects (if the CI crossed zero, the result was considered insignificant). Hypothesis 1 tested the first model on the full sample ( $N = 297$ ), and assessed whether therapist status moderated the impact of attachment anxiety, shame-proneness, and the fear of invalidity on personal distress empathy; and, thus, the indirect effect between attachment anxiety and personal distress empathy. Hypothesis 2 assessed whether personal therapy sessions moderated the impact of attachment anxiety, shame-proneness, and the fear of invalidity on personal distress empathy; and, thus, the indirect effect between attachment anxiety and personal distress empathy. Hypothesis 3 drew from the sub-sample of therapists ( $n = 139$ ) to assess whether both personal therapy *and* therapist experience level moderate the effect of attachment anxiety, shame-proneness and the fear of invalidity on personal distress empathy; and, thus, the indirect effect between attachment anxiety and personal distress empathy.

#### Preliminary Analyses

A total of 322 individuals were recruited for the study. Of these protocols, 16 were identified as incomplete, and 9 were identified as multivariate outliers (i.e., having combinations of unusual scores on at least two variables), by the Mahalanobis  $D^2$  test. Excluding these 25 cases was unlikely to impact the statistical power of our analyses, so list-wise deletion was employed, resulting in a final sample size of  $N = 297$ . As indicated on Table 1, all variables fell below the acceptable standard of skewness and kurtosis (Kline 1998). Variables were mean centered to reduce multicollinearity,

or inter-correlations between the variables and interaction variables. Since therapists were older than non-therapists (Table 1), and age was associated with the dependent variable,  $r(295) = -.25, p < .001$ , we included age as a covariate in all analyses.

## Hypothesis Testing

### Hypothesis 1

We tested the first hypothesis with the full model ( $n = 297$ ), and examined whether therapist status moderated the path between attachment anxiety, shame-proneness, and the fear of invalidity on personal distress empathy; and, thus, the indirect effect of attachment anxiety and personal distress empathy. The index of moderated mediation, which measured the difference in indirect effects, suggested that the effect of attachment anxiety on personal distress empathy through shame-proneness did not vary as a function of therapist status ( $b = -0.02$ ;  $SE = 0.22$ , 95%  $CI -0.463$  to  $0.409$ ), though the indirect effect of attachment anxiety on personal distress empathy through the fear of invalidity *did* vary as a function of therapist status ( $b = -0.53$ ;  $SE = 0.29$ , 95%  $CI -1.143$  to  $-0.005$ ). An examination of the conditional indirect effects revealed that the indirect of attachment anxiety on personal distress empathy through fear of invalidity was stronger among non-therapists ( $b = 1.03$ ;  $SE = 0.25$ , 95%  $CI 0.567$  to  $1.570$ ) compared to therapists ( $b = 0.50$ ;  $SE = 0.20$ , 95%  $CI 0.111$  to  $0.906$ ).

### Hypothesis 2

For the second hypothesis, we examined whether personal therapy moderated the path between attachment anxiety, shame-proneness, and the fear of invalidity on personal distress empathy; and, thus, the indirect effect of attachment anxiety on personal distress empathy. Due to the impact of therapist status in the prior model, we tested this hypothesis separately with the therapist ( $n = 139$ ) and non-therapists ( $n = 158$ ). Among therapists, the indirect effect of attachment anxiety on personal distress empathy through shame-proneness did not vary as a function of personal therapy sessions ( $b = 0.01$ ;  $SE = 0.04$ , 95%  $CI -0.100$  to  $0.076$ ), nor did the indirect effect of attachment anxiety on personal distress empathy through the fear of invalidity ( $b = 0.02$ ;  $SE = 0.07$ , 95%  $CI -0.094$  to  $0.208$ ). Among non-therapists, the indirect effect of attachment anxiety on personal distress empathy through shame-proneness also did not vary as a function of personal therapy sessions ( $b = -0.09$ ;  $SE = 0.14$ , 95%  $CI -0.313$  to  $0.244$ ) nor did the indirect effect of attachment anxiety on personal distress empathy through fear of invalidity ( $b = 0.08$ ;  $SE = 0.09$ , 95%  $CI -0.140$  to  $0.237$ ).

### Hypothesis 3

Our last model was tested using the sub-sample of therapists ( $n = 139$ ), and originally intended to assess the effect of both personal therapy *and* therapist experience level on the relationships between attachment anxiety, shame-proneness, and the fear of invalidity on personal distress empathy; and thus, the indirect effect of attachment anxiety on personal distress empathy. Since personal therapy did not significantly impact this mediation in the former model, however, we retained only therapist experience level as a moderator. Results indicated that therapist experience level did *not* moderate the path between shame-proneness and personal distress empathy,  $b = 0.12$ ;  $SE = 0.07$ ,  $t(130) = 1.68$ ;  $p = .095$ ; yet, therapist experience level *did* moderate the path from the fear of invalidity to personal distress empathy,  $b = -0.11$ ;  $SE = 0.05$ ,  $t(130) = -1.99$ ;  $p = .049$ . We used the Johnson-Neyman technique to locate the turning point of where exactly, on the continuum of therapist experience level, the relationship between the fear of invalidity and personal distress empathy turned from significant to insignificant. Results indicated that the fear of invalidity was related to personal distress empathy among those with 88.66 months (i.e., 7.38 years) of therapist experience or fewer,  $B = 0.09$ ,  $SE = 0.05$ ,  $t(130) = -1.97$ ,  $p = .05$ , and this “region of significance” included 73.38% of the sub-sample ( $n = 102$ ). However, among the remaining 26.62% with over 88.66 months of therapist experience ( $n = 102$ ), the fear of invalidity was unrelated to personal distress empathy. Although the constituent path between the fear of invalidity and personal distress empathy varied as a function of therapist experience level, the indirect effect of attachment anxiety on personal distress empathy ultimately did *not* ( $b = 0.02$ ;  $SE = 0.07$ , 95%  $CI -1.094$  to  $0.092$ ).

## Discussion

The current study sought to examine an aspect of the empathic dialectic marked by emotional resonance, which has been alluded to by contemporary psychoanalytic theorists of the empathic process (Buechler 2008; Ehrenberg 1992; Holmes and Slade 2018), and validated by social neuroscience research (Decety and Lamm 2009). In order to do so, the current study aimed to identify the conditions under which personal distress empathy is relatively unassociated with other facets of poor self-regulation (i.e., attachment anxiety, shame-proneness, and the fear of invalidity), in a sample of 158 non-therapists and 139 therapists. Our findings suggested that therapist status significantly and negatively impacted the relationship between the fear of invalidity (but, not shame-proneness) and personal distress empathy, and thus, the relationship between attachment

anxiety and personal distress empathy. Yet, personal therapy did not have a significant effect on the proposed mediation model. In the following section, we will review our results in detail, focusing our discussion on their relevance to the therapeutic empathic dialectic.

### The Many Faces of Personal Distress Empathy

Results partially confirmed the first hypothesis: therapist status significantly and negatively impacted the relationship between the fear of invalidity and personal distress empathy; which, in turn, negatively impacted the otherwise positive relationship between attachment anxiety and personal distress empathy. Attachment anxiety involves a view of the self as inherently bad (Griffin and Bartholomew 1994), and the fear of invalidity is similarly marked by the tendency to doubt one's perceptions and experiences (Thompson and Zanna 1995). Assuming personal distress empathy (i.e., negative feelings in response to the distress of others) is likely to emerge during ruptures in the therapeutic alliance, it seems likely that attachment anxiety and the fear of invalidity interfere with therapists' ability to self-regulate, and thus inhibit their capacity for empathy. Indeed, regulating the emotional reactions that arise during difficult therapeutic moments is likely to require a degree of security and certainty, which is absent among those with attachment anxiety, self-doubt, and uncertainty (i.e., the fear of invalidity). In direct contrast, attachment security helps one to co-regulate others' distress (Holmes and Slade 2018), holding their dysregulation while participating in their arousal "so that the brains join and become a single healing system" (Hasson et al. 2012, cited in Badenoch 2018, p. 84). Personal distress empathy may *less* associated with the fear of invalidity and attachment anxiety among therapists (compared to non-therapists), because it provides therapists with important emotional information about patients' states of mind, enhancing their capacity to co-regulate patients' distress.

Disconfirming our second hypothesis, the self-regulation that is often acquired by those who regularly attend (or have attended) personal therapy did not appear to impact the effect of shame-proneness or the fear of invalidity on personal distress empathy; and, thus, it did not impact the effect of attachment anxiety on personal distress empathy. It is possible that we lacked the statistical power to detect relationships between personal therapy and our study's variables. However, it is also possible that, as individuals learn to regulate their experiences of personal distress empathy within the context of personal therapy, the "discrete neural networks" that govern automatic processes of emotional contagion (Decety and Lamm 2009) operate under the threshold of their conscious awareness. Though more research is needed in this area, it may be that learning to self-regulate through personal therapy differs from learning

to self-regulate through therapist experience; specifically, it may require less conscious awareness about personal distress empathy and its associated traits and states.

Partially confirming the third hypothesis, the fear of invalidity was related to personal distress empathy among those with less than 88.66 months of therapist experience (but, it was no longer related to personal distress empathy, among those with more). Therapist status and therapist experience level may negatively affect the relationship between the fear of invalidity and personal distress empathy, because therapists' experience of personal distress empathy is uniquely un-tinged by self-doubt and uncertainty (i.e., the fear of invalidity). Conversely, therapist status and therapist experience level may *not* have affected the relationship shame-proneness and personal distress empathy, because having an awareness of this emotionally laden trait is consistent with a form of personal distress empathy that is unique to therapists. It is possible that this form of personal distress empathy facilitates "pain empathy" (Goubert et al. 2009), or one's capacity to mirror another's pain, and may be a vital component of one's engagement in the empathic dialectic during difficult therapeutic moments (e.g., rupture events). In order to fully investigate this idea, however, more research is needed which examines the construct of pain empathy among therapists.

### Conclusions

Principally, our results indicated that the fear of invalidity explained the association between attachment anxiety and personal distress empathy, and this mediation was stronger among non-therapists when compared to therapists. Interestingly, however, personal therapy did not appear to impact relationships among the variables in our model. We presented one potential interpretation of these findings: namely, that personal distress empathy is a form of emotional resonance that may be uniquely adaptive among therapists, providing emotional information to therapists about their patients' distressing and/or dysregulated states of mind. However, further research on personal distress empathy is needed, before definitive claims about the therapeutic use of this trait can be made.

### Limitations

The first and most notable limitation of this study was the use of a cross-sectional design to capture the impact of personal therapy and/or therapist experience level on one's capacity for emotional resonance. Maxwell and Cole (2007) recommend a longitudinal design to capture phenomena that are thought to develop over the course of time. A second limitation involved the unbalanced nature of the sample,

which included a higher number of non-therapists (compared to therapists), and non-therapists with a wide range of personal therapy. Stratified random sampling could have ensured a more even distribution of individuals, based on personal therapy and therapist experience. The third limitation involved the use of self-reports, which are vulnerable to social desirability bias (Van de Mortel 2008). Fortunately, this last limitation may have been mitigated by our online platform, which tends to elicit responses that are in line with participants' true beliefs (Gosling et al. 2004).

## Future Research

Future research should continue to investigate therapeutic empathy, from the theoretical standpoint of the therapeutic empathic dialectic. Specifically, the current study's implications about pain empathy may be further investigated. Social neuroscience research suggests that pain empathy "could have a debilitating... impact on observers, [thus] those who display a moderate amount of accuracy... might be the most effective caregivers" (Goubert et al. 2009, p. 161). Future research could enrich our understanding of therapeutic empathy, by investigating the extent to which the empathic dialectic is marked by emotional resonance, and degree to which it involves therapists' personal distress.

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## Compliance with Ethical Standards

**Conflict of interest** The authors declare that they have no conflicts of interest.

**Ethical Approval** All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. The project has been approved by the Institutional Review Board at Long Island University, New York.

**Informed Consent** Informed consent was obtained from all individual participants involved in the study.

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